#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 37501 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Wear 21 2004 4c.-County of Death 4b. City, Town, or Location of Death de GRA MEMORIAL HAPITAL HAVRE If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, XXM 2□F MARYLAND 54 1950 JUNE 29 10b. County 10c. City, Town or Location ABERDEEN HARFORD CO 10g. Citizen of What Country? 10f. Zip Code S.A. 21001 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

**Physician** 2.25 AM /Medical 4a. Fecility Name (If not institution, give street and number)\_ Examiner Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Director 220-52-3148 Usual Residence of Decedent 10d. Inside City Limits 10a, State 1 ☐ Yes 2X No Director MARYLAND 10e. Street and Number 410 DORSEY STREET 11. Marital Status 1XXVes 2 □ No If Yes, Give Year or Dates: 68/72 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify: þ 3 Widowed 4 Divorced BLACK Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12yrs FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LUCY WOODLEY CLARENCE RIDGLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 410 Dorsey St., Aberdeen, Maryland 21001 Bernice Ridgley/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 11-27-04 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, PA. 321 S PHILADELPHIA BLVD., ABERDEEN, MD 21001 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Into the sea ... or complications the shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) (or as a consequence of); Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1. Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 - Homicide

**Examiner** be executed Box 68760, Director: within 24 hours after To the Funerel Direct ō

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marked other

cartment of Health a cartent: If item 27 is mjury or other tre

**Physician** /Medical

h and Mental I

Maryland 21215-0036

Baltimore,

H80C

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year)

MO, IME 32. Registrar's Signature

completed cause

NOV 2 9 2004

of death (Item 23a) (Type, Print)

BALTO Mol 2022 7

within 2 To the the

> Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certified

31. Date file OV

uniona

mill

32. Registrar's Signatus

KOREL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number OCME

29d. Date signed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

November 28, 2004

			For State Registrar	State	of Marylar	•	artment of rtificate of		d Men		ne 2001	+ 3	7503
	Physici /Medic		Decedent's Name (First, Mide     Ma.:	ry Louise	Rose					Date of Death Month OVEMB	Day Yea	r	Time of Death
	Examin		4a. Facility Name (If not institution  St. Agn ES	Health			BAG	or Location of D	RE		4c. County of De	A	
	Funeral Director		5. Social Security Number 404-26-3257	6. Sex 1 ☐ M 2 <b>X</b> F	7. Age (In yrs. 81	last birthday) Yrs.	Months Days		lin.	Date of Birth Month, Day, Yo r. 3, 1	9. E 1923 K	Birthplace ( Country) entuc	State or Foreign ky
	Aaryland f show	or	Usual Residence of Decedent  10a. State 10b. Count  MD	n/A	10c. Ci	ty, Town or Lo	cation Balti	more		<del> </del>			side City Limits  Yes 2 □ No
	with the Na or 28e-	Funeral Director	10e. Street and Number 3306 English	-	nue		10f. Zip Code	1230		-	Citizen of What		
936	d within 72 hours after death with the Maryland liene. I then "natural", or liems 23s or 28e-f show The Medical Examinat must be notified at	by	11. Marital Status  1 Never Married 2 Mar 3 Widowed 4 Divorce	12. Was De	cedent Ever in U orces? 2 XNo ive		Was Decedent of II Yes, specify Cui 1 ☐ Yes 2 🛣 No	oan, Mexican, Po	? (Specify uerto Rica	Yes or No- n, etc.)	14. Race - Ai Black, W Specify:		
21215-0036	I within iene. r then "	Completed		ent's Education lest grade completed College	) (1-4or 5+)	(Give	dent's Usual Occu kind of work doni DO NOT use retir ursing T	during most of ad		16	b. Kind of Busine		
Maryland 2	be filed stal Hyg od othe event,	To Be C	17. Father's Name (First, Middle Aaron Anderson					18. Mother's	Name (Fi	rst, <i>Middle, Mai</i> mily Wr	iden Sumame)		
Mary	and and ls m		19a. Informant's Name/Relation				, , , , ,				ity or Town, State		
Baltimore, I	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr once.	,	Elmo Rose Hus  20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other  21. Signature of Funeral Service	n 3 □Removal from (Specify)	State Me	Place of Dispo cemetery, cre adowri	osition (Name of matory or other pl dge Memo Park	rial	Date -24-2	004 E1	Lmore M c. Location - City Lkrid e eral Home	or Town, S	tate
<u> </u>	88188		Sa Part . Enter the disease,	or complications that	caused the dea	2	719 Hamm	onds Fe	cry R	d., Lar	nsdowne,	MD 2	1227 oximate
	Pnysician /Medical		shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	st only one cause on	each line.	STAT	IC BR					Onse	val Between et and Death MONTH 5
	Examiner	ner	Sequentially list conditions, if any, leading to immediate	b	(or as a consec								
68760,	icate be executed physicien and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a consec	quence of):							
O. Box	The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live	utcome of pregn birth 2 Pet gnant at time of o	al death 3	⊒Ectopic pregnan ☐ Other (specify)	су		<u> </u>	23d. Date of Month	delivery Day	Year
<u>α</u>	quires that n signed b uld be deta	by	Part II. Other significant condi	tions contributing to	death but not re	sulting in the u	nderlying cause g	iven in Part I.			cco use contribute		se of death?
Vital Records,		Completed							_	24a. Was an autopsy performer	d? prior to death	to completi	ndings available on of cause of
Vita	Physicien: The this certificate ral director, pag	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☒ No	Hospital:	Inpatient 2	TER/Outpatie	nt 3 DOA	thon		neck only one) 5 ☐ Residence	e 6 □Other (S	necify)	
ion of	ding h. After fune		27. Manner of Death 1 X Natural 5 ☐ Pend	28a. Dat	of Injury onth, Day Year)	28b. Time of Injury	f 28c. Inj		3		injury occurred	,	
Division	i i te o	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	rmined 286. Plac	ce of Injury - At h ding, etc. <i>(Speci</i>		reet, factory, office		281.	Location (Stree City or Town, S	et and Number or State)	Rural Rou	te Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical		ying Physician: To to al Examiner: On the and ma									ause(s)
	To the To the compl	Me	29b. Signature and title of certification	threed.	M.D			Di669	8		Date signed (Mo		
	P		30. Name and address of person Dr. Nadee	4 1		m 23a) (Type,	Print) Cator	Aver	100	Balti	more M	arsia	nd 21229
	Sta Regist		31. Date filed (Month, Day, Yea	ar) 32.	Registrar's Sign	ature	9 1						

ROSE, MARY

		-	State of N  - State Registrer		artment of Health and Natificate of Death	Mental Hyglend Reg. No	711111 2 1505
t Mg	Physici	_	1. Decedent's Name (First, Middle, Last)  Sylvia Spence			2. Date of Death Month Da	
	/Medic Examin		4a. Facility Name (If not institution, give street and number AAMC	7)	4b. City, Town, or Location of Death Annapolis		Ecounty of Death Anne Arunde
	Funeral Director		5. Social Security Number 6. Sex 116-10-4836 1□ M XXF 7. A	Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Month, Day, Year 11/8/1916	9. Birthplace (State or Foreign Country) NEWARK, NJ
	show	'n	Usual Residence of Decedent	10c. City, Town or Lo			10d. Inside City Limits 12⊒Yes 2 □ No
4	or 28a-f	Directo	10e. Street and Number	ANNAFOL	10f. Zip Code	10g. C	itizen of What Country?
36	in returnity or itams 23s or 28s-1 show isglical Examinational be notified at	by Funeral Director	1010 TALLWOOD ROAD  11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced  12. Was Deceder Armed Force: If Yes, Give Year or Dates	□ No	21403 Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify:WHITE
Maryland 21215-0036		Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-40	16a. Dece (Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	GO	Kind of Business/Industry VERNMENT
and 21	ntal Hygi od other event, I	o Be	12  17. Father's Name (First, Middle, Last)  JOSEPH BERNSTEIN	PRES		e (First, Middle, Maide	
Mary	h and h	-	19a. Informant's Name/Relationship (Type, Print)  JO-ANN DAUM		ng Address (Street and Number or RullINTON AVENUE, BAB		
ο ·	of Heal itam 2 rother		20a. Method of Disposition  1 ○ Surial 2 □ Cremation 3 □ Nemoval from Sta  1 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo	osition (Name of matory or other place)		ocation - City or Town, State
Baltin	permit. Page Department of Important: M any injury of once.		21. Signification Service Licens &  KELLY GREGORY FINK #1	2	2. Name and Address of Facility FI	NK FUNERAL	HOME, PA
	mysician /Medical Examiner	ler	resulting in death)  Due to (or Sequentially list conditions, if any, leading to immediate	amonia.	active Pulma		Approximate Interval Batween Onset and Death
9760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Ilcal Examiner	cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last  C.  Due to (or	as a consequence of):			
.O. Box 6	he death certifics the attending pt ched for use as t	Physiclan/Med		n 2 ☐ Fetal death 3[ t at time of death 5[	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ds, P.	uires that the di signed by the lid be detached	þ	Part II. Other significant conditions contributing to deat	h but not resulting in the t	underlying cause given in Part I.	· married	use contribute to the cause of death? 2 🗋 No 3 🗎 Probably 4 🗍 Unknown
		Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
	ding Physician: Th h. After this certificate funeral director, pag	To Be	27. Manner of Death Natural 5 Pending  28a. Date of l (Month,	atient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing H	ome 5 Residence 28d. Describe how inj	
á	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be 28e. Place of	Injury - At home, farm, si , etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	e Hospital 124 hours a e Funeral I letely filled	edical C	29a. Certifier (Check only one) Certifying Physician: To the basis and manner	s of examination and/or in	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	m)	29c. License number	29d. C	Date signed (Month, Day, Year)
(	3/4,		30. Name and address of person who completed cause	of death (Item 23a) (Type	Print)		
	S: Regis	tate trar	31. Date filed (Month, Day, Year) 32. Reg	strar's Signature	South		

			1 - For State Registrar	State of Ma	aryland		artmen rtificate			and Me		iepe <sub>og. No.</sub> O	04	37506
	Physici /Medic		1. Decedent's Name (First, Middle, Kenneth Davi		•						Date of Deat Month NOV.	h Day 26	2004	3. Time of Death 5:55 p M
	Examin		4a. Facility Name (If not institution, 325 West Cherry						Location o	wn		Ba:	unty of Death ltimore	
	Funeral Director		212-01-8834	6. Sex 7. Ag 1 1 1	85	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. J	Date of Birth Month, Day, ULY	1999	9. Birthp Cour Mary	lace (State or Foreign Itan) Land
	Maryland f show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Balt	imore		Town or Lo		n					1	0d. Inside City Limits 1 ☐ Yes 2 No
	with the 3a or 28e-	i Direct	10e. Street and Number 325 West Cherry	Hill Ct.			10f. Zip	Code	136		1	-	of What Cour	ntry?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show amportent: If item 27 is marked other than "natural", or items 23a or 28e-f show appring injury or other treumetic event, the Medical Examinat must be notified at an once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marrie  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? ad 1 M Yes 2 ☐ If Yes, Cive, Year or Dates:		1	Was Deced If Yes, spec	7.5	spanic Orig n, Mexican Specify:	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)		Race - Americ Black, White, ecity: Whit	etc.
21215-0036	within 72 hou iene. • than "nature ihe Modical E	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or 5	5+)	(Give life.	dent's Usua kind of wor DO NOT us Licema	rk done d se retired,	ation furing most )	of working			timore	County
Maryland 2	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, L Eli Kelly Sho								First, Middle, M		name)	
	and 2 sho laith and 1 127 is ma er treume		19a. Informant's Name/Relationsh Lawrence Shock				-				Route Number  Reist			Code)
Baltimore,	Pages 1 ament of He ent: If item ury or oth	00	20a. Method of Disposition 1 □ Qurial 2 □ Cremation 1 □ Donation 5 □ Other (Sp		се	ace of Dispo metery, crei ers Ch	matory or o	ther place		Dat			on-City or To erville	
Balt	permit. Departi Import any inj		21. Signature of Funeral Service L	icensee 3		E (	Name and khard	d Addres lt Fi Reist	s of Facility Inera. Lers to	l Char Own R	pel P.A	igs Mi	ills, M	ld. 21117
THE STATE OF	Cate be executed /Medical Examiner the burial-transit	icai Examiner	23a. Part1. Enter the disease, or a shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or highly that initiated events resulting in death) Last	a	a consequ	ence of):				Q		est,		Approximate Interval Between Onset and Death
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3[	Ectopic pr					23d.	Date of delive	nry Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant condition	s contributing to death b	ut not resu	lting in the u	nderlying ca	ause give	n in Part I.		23e. Did tob	^		ably 4 Unknown
I Reco	ilcian: The law requ certilicate has been rector, page 2 shouli	Completed	0								24a, Was a autops perform	v	prior to cor	psy findings available inpletion of cause of
of Vita	Physician: r this certificinal director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No			ER/Outpatier			r: 4 □ Nui	rsing Home	Check only on	nce 6 🗆		<i>'</i> )
Division of Vital Records,	To the Hospital or Attending Physician: The lar within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of Death  1 Shatural 5 Pending  2 Accident investig  3 Suicide 6 Could n  4 Homicide determine	ation on Sleep of le	jury - At hor	28b. Time o Injury me, farm, sti	М		at ? ∕es 2⊡h	No	d. Describe ho  f. Location (St. City or Town	reet and Nu		l Route Number,
	ne Hospita 24 hours ne Funeral letely fillec	Medical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis o and manner st	f examinati	vledge, deat ion and/or in	h occurred vestigation,	at the tim in my op	e, date and sinion, deat	d place, and	d due to the ca at the time, da	use(s) and ate and plac	I manner as st	ated. the cause(s)
)	To th withir To th comp	Me	29b. Signature and title of certifier	le		,		License	number			d. Date sig	gned (Month,	Day, Year)
	6		30. Name and address of person v	ho completed cause of c	death (Item	23a) (Type,		*	2	e iste	ntow.	~ ~	-3 21	136
	Sta Registr	3	31. Date filed (Month, Day, Year) NOV 2 9	2004 32. Registr	ar's Signat	ure	£	7.02						

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04-6 AKG	5531			for State Registrer	State	of Maryla				Death		_	Reg. No	200	4	375	07
		Physici	g: ,	Decedent's Name (First, Middle							2	2. Date of De Month _	Da	ıy Y	ear	3. Time of D	
4		/Medic		SANDRA LE				1 01			10 11	Octob		200		7:40 E	) M
		Examin	ier	4a. Facility Name (If not institution						r Location o				. County of			
				5229 Marlboro 5. Social Security NumbelUnk		303 7. Age (In vr	s. last birthday	+		Heigh		B. Date of Bir	th	rince	. Birthola	ce State or	Foreian
	50/	Funeral Director		Usual Residence of Decedent	1□M 2 <b>XX</b>	49	-	Months	Days	Hours	Min.	(Month, D.)	1955	W	ASH1	NGTON	D.C.
	paela	thow	_	10a. State 10b. County			City, Town or I		umo						10	d. Inside City	
	M of	or 28a-f show	Director		CE GEORGE	S C	APITAL						10- 0	hi			: 🗆 140
	4	a or 2	급	10e. Street and Number	DTVE			107. 2	p Code				_	itizen of Wha JSA	at Count	ry r	
	4	PS 238	eral	529 MARLBORO		cedent Ever in	U.S. 13	. Was Dece	edent of H	lispanic Ori	gin? (Spec	ify Yes or No		14. Race -	America	n Indian,	
	36	within 72 nours affer death with the maryland ene. Than "natural", or Items 23a or 28a-f show re M. Jigal Ex., nither notal be notified at	by Funeral	1 Never Married 2 Married 3 Widowed	ried 1 Tyes	Forces? 2. <b>XX</b> io 3ive		If Yes, spi	ecity Cuba	Specify:	1, Риепо н	ican, etc.)		Black, Specify:	White, e	tc. HITE	
	21215-0036	n /2 nours "natural", "Jical Ex	Completed by	(Specify only highe			16a. Dec (Giv life.	edent's Usi re kind of w DO NOT	ual Occup ork done	ation during mos d)	t of working	7	16b. k	Cind of Busin	ness/Ind	ustry	
	212	r than	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)		unk	nown					unkn	own		
		ntal Hygie ad other sevant, tr	Be	17. Father's Name (First, Middle, FRANK J. SANT						18. Mothe		First, Middle			NE		
	Maryland	s 1 and ∠ should be filed withit t Heath and Mental Hygiene. itam 27 Is marked other than other traumatic evant, Ite M	5	19a. Informant's Name/Relations	ship (Type, Print)	ramurd					er or Rural	Route Numb	er, City	or Town, Sta	ate, Zip (	Code) 34668	
	e, ∈	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or othar trai 20029.	l	FRANK J. SANTO	JIEMMA -		. Place of Dis	position (Na	me of	1	DR. PO			ocation - Ci			<b></b>
	Baltimore,	Pages ent of nt: If it ry or o		1 Burial 2 Memation 4 Donation 5 Other (S			cemetery, ci AYVIEW				11/24	/2004	BAI	TIMOR	Ε, Μ	D	
	altii	permit. I Departm Importai any injui		21. Sign 649 o Funeral Service								YLAND					
	Ω :	88258	An ii		FINK #MO							., GLE		JRNIE,		21061 Approximate	
		Physician /Medical Examiner	8	23a. Pant. Enter the disease of shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a Meth	each line.  adone J o (or as a cons	[ntoxic			ig, 30011 03						Interval Betw Onset and De	een
		icate be executed physician and s the burial-transit	dical Examiner	Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>c</b>	o (or as a cons											
	P.O. Box 6	Physician: The law requires that the death certificate be this certificate has been signed by the attending physicial director, page 2 should be detached for use as the but	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ yes 2 □ No 9 □ Unknown	1 Live	outcome of precessions of precession	etal death 3	B⊟Ectopic i⊟ Other (s		y 				23d. Date of Month			ear
	rds, P	quires that n signed b		Part II. Other significant conditi	ions contributing to	death but not r	esulting in the	underlying	cause grv	ven in Part I	l. 		7	\ /		e cause of de	
	of Vital Records,	iician: The law requir certificate has been s' rector, page 2 should	Completed									Y Yes	psy ormed? 2   N	prio	or to com	sy findings as appletion of car	vailable use of
	Z Z	siciar certif irecto	o Be	25. Was case referred to medica examiner?  XXYes 2 \sum No	Mosnital:	☐Inpatient 2	☐ ER/Outpati	ont 30 c	Ott			Check only		€ <b>V</b> Other	(Spanify	at sce	ene
	on of	ding Phys h. After this funeral dii	I	27. Manner of Death 1 □Natural 5 □ Pendi	ng Four	te of Injury	28b. Time	ind <sub>M</sub>	28c. Injur Wor		28	3d. Describe	how inju	ary occurred	unk	•	110
	Division	To the Hospital or Attending Pl within 24 hours after death. To the Funaral Diractor: Atter it completely filled in by the tuneral	Certification;	2 Accident Invest 3 Suicide SX Could 4 Homicide detern	mined 28e. Fla	1/04 ice of Injury - Ai ilding, etc. (Spe ind in I	6:00 t home, farm, cify)	<b>p</b> street, facto			28	If. Location ( City or To	wn, Stat	<sup>(a)</sup> 5229	) Ma:	Route Numb	Pike
	:	Hospite 24 hours Funara stely fille	edical C		ng Physicien: To t I Examiner: On the	the best of my k	nowledge, de	ath occurre			nd place, ar	nd due to the	cause(s	s) and mann	er as sta	ited.	
		ro tha within Fo the comple	Me	29b. Signature and title of certific		1		2	9c. Licens	se number			29d. Da	ate signed (	Month, D	lay, Year)	
		->-0		> ( home	The	Scall	- pur	)	0.	.C.M.E	₹.		Oct	ober	10,	2004	
				30. Name and address of person	who completed ca	ause of death (I	tem 23a) (Typ		Penn	Stree	et. B	altimo	re	Marvl	and	21201	
	:- () - ~	St Regist	ate trar	31. Date filed (Month, Day, Year NOV 2		Registrar's Sig	gnature		lon		,		-,-	<u>,</u>			

			For State Registrer	State of Ma	ryland		artment of F ctificate of I		d Mental Hy	giene Reg. No.	1 1 23	37508
	Physicia	an	1. Decedent's Name (First, Middle, Las Lawrence	C. Smi	t h				2. Date of De Month	Day		3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of De	Novem		County of Dea	
	Examin	er	SATAT AUNE		+ cA	RE		IMOR		70.	o outring or or or or	м
E	Funeral Director		5. Social Security Number 6. S			ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	rs. 8. Date of Bi	7 19	9. Bir 27 Md	thplace (State or Foreign ountry)
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Lo	cation					10d. Inside City Limits
	Maryla f sho	Į.	Md Howard			ooksvi						1 ☐ Yes 2 X No
:	death with the Maryland ms 23e or 28e-f show	I Director	10e. Street and Number 14092 Monticello	Drive			10f. Zip Code 21723	<del>-</del>	_	10g. Citi USA	izen of What C	ountry?
950	be filed within 72 hours after death with the Marylan Hygiene. I et Hygiene.	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 11 1 Yes 2 □ No If Yes, Give Year or Dates:		т	Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or Ne erto Rican, etc.)	D-	14. Race - Am Black, Whi Specify: Wh	te, etc.
212-0030	within 72 ho ene. then "netur	Completed	15. Decedent's Ec (Specify only highest gra	lucation de completed) College (1-4or 5+	+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired Ontractol	during most of v d)	working		nd of Business	
A	filed w Hygien other th	Cor	12 17. Father's Name (First, Middle, Last)				Olici acco.		lame (First, Middle	ļ.,		
		To Be	Coleman Smith						arrie Fra			
<u> </u>	s 1 and 2 should be I Health and Mental Item 27 is marked other treumatic ev	-	19a. Informant's Name/Relationship (*) Dolores C. Smith				-		Rural Route Numb Cooksvi	-		
more,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre once		20a. Method of Disposition  1 XBurial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specification of the content		20b. Pla ce Wood	ace of Dispo emetery, crer 11awn	sition (Name of matory or other plac Cemetery	12-	Date -3-04		imore,	
Baitimor	permit. Departm Importe any inju		21. Signature of Funeral Service Licer	-1 -1	4				Haight Fu			& Chapel
ļ	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each line	the death e.	. Do not ent	_			rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):	(a yo					
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (o as a	consequ	ence of):	h fai	r fa	INVE			unchewh
Ď,	icate be executed physician and s the burial-transit	I Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	as a consequence of):					_		
08/PU	icate b physic s the b	edlcal		d								
	The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of the control	2 🗌 Fetal	death 3	Ectopic pregnancy Other (specify)	/			23d. Date of de Month	livery Day Year
ds, P.	w requires that fl s been signed by should be detac	by	Part II. Other significant conditions of			itting in the u	nderlying cause giv	en in Part I.		tobacco u		the cause of death?
Hecords,	w requ	letec	12 61100	LL ( ( )					24a, Was			utopsy findings available
		Completed							1 Tes	2 X No	prior to death? 1 ☐ Yes	completion of cause of
VItal	ysicial s certit directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatier	nt 2 🗆 £	ER/Outpatier	at 3□ DOA Oth	0.00	Death (Check only Home 5 Res		6 □Other (Spe	cify)
Division of	nding Phi th. r: After thi e funeral		27. Manner of Death  1 Salatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year)	28b. Time o Injury	Wor		28d. Describe			
DIVIS	To the Hospitel or Attending Physicien: whith 24 hours after death. To the Funerel Director. After this certifica completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injubuilding, etc.			eet, factory, office		28f. Location ( City or To	Street an wn, State	d Number or R )	ural Route Number,
	ne Hospit n 24 hour ne Funere pletely fille	Medical (		ysician: To the best o niner: On the basis of and manner stat	examinat							
	To the within To the comp	Ž	29b. Signature and title of certifier				29c. Licens				e signed (Mon	
	V		1 Don Go	1 Resula				8615		NOV	le un bev	29,2004
_	M		30. Name and address of person who RCSaler NA V.E.	completed cause of de	Ca	23a) (Type, EON	avenu	e 1 ba	Utimo	ve,	MD	21228.
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2, 9, 2004	32. Registra	r's Signat	die de la constitución de la con	te la		ltimo			

Lawrence, Smith

1 - State Certificate of Death Reg. No.	
6 Dead and March (First Mindle Leat)	004 37509
Physician (Medical Annual Elizabeth Scott 2. Date of Death Month Day November	3. Time of Death 27 2004 12 30 AM
Examiner 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. City	County of Death
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foleign
Director  Usual Residence of Decedent	4 Country PA
7	10d. Inside City Limits
10a. State 10b. County 10c. City, Town or Location  Town Street and Number 10f. Zip Code 10g. Citiz	1 ☐ Yes 2 1 No zen of What Country?
Toe, Street and Number  10e, Street and Number  10f, Zip Code  10g, Citiz  11. Marital Status  1 Never Married  1 Never Marri	USA
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?)  14. Marital Status  15. Was Decedent of Hispanic Origin? (Specify Yes or No-Hyes, specify Cyban, Mexican, Puerto Rican, etc.)	Race - American Indian,     Black, White, etc.
1 Never Married 2 Married 1 Yes 2 No In Ye	Specify: BACK
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)  16b. Kin  16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)  16b. Kin  16c. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)  16c. Vin  16c. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)	nd of Business/Industry
TO BEEFE TO THE GRADE TO THE STATE OF THE ST	L KS
Durklar of the first, Middle, Last)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden state)  19a., Informal Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Rural Route Number, City. or	NS
Top of the stand of the stand Number of Number	Town, State, Zip Code)
Description  20a. Method of Disposition  20b. Place of Disposition (Name of cometery, crematory or other place)  1 Method of Disposition  1 Method of Disposition  1 Method of Disposition  20c. Loc 20c. Loc	cation - City or Town, State
La g g g g g g g g g g g g g g g g g g g	nas Muls, Mo
21. Signature of Funeral Service Licensee  22. Name and Address of Facility Quantum Common Service Licensee  23. Signature of Funeral Service Licensee  24. Name and Address of Facility Quantum Common Service Licensee	LIISTOWN MOZIA
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Appr ximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	3 years
Examiner Sequentially list conditions b. liver metastages	3 years
Sequentially list conditions, if any, leading to anniadate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
O o c c c sulting in death) Last Due to (or as a consequence of):	
dictions of the state of the st	
in the past \$2 months?	3d. Date of delivery  Month Day Year
O of the past in past in the past in past	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco us	se contribute to the cause of death?
Peccords  The law requires some law requirements and law requirements some law r	24b. Were autopsy findings available
	prior to completion of cause of death? 1 □ Yes 2★ No
25. Was case reterred to medical examiner?  1   Yes   2   No    25. Was case reterred to medical examiner?  1   Yes   2   No    26. Place of Death (Check only one)  Other: 4   Nursing Home 5   Residence 6	Cothos (Conside)
A see	
28a. Date of Injury    28b. Time of   28c. Injury at   28d. Describe how injury   28d. Describe how in	Number or Rural Route Number,
A D TO TOWN, State)  4 Homicide determined building, etc. (Specify)	
2   Accident   3   Suicide   4   Homicide   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and City or Town, State)	and manner as stated. place, and due to the cause(s)
29b. Signature and title of certifier 29d. Date	signed (Month, Day, Year)
296. Signature and title of certifier  AJJAI ALVA, MD, ST. AGNES HEALTHCARE, BUTTON AJJAI	more al, aug
	ALTIMORE, MD
State Registrar NOV 2 9 2004 32. Registrar's Signature	

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Americation a 20 and / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month Day **Physician** 9:50 PM 25 2004 November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5 Social Security Number 6. Sex 8. Date of Birth Jonth Day, 7. Age (In yrs. last birthday) **Funeral** Days Hours 68.280 100 M 2□F Yrs. Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits other treumatic event, the Madical Exposper qual be notified at 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Iteme 23a Race - American Indian, Black, White, etc. 1. Marital Status Pages 1 and 2 should be filed within 72 hours after c nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Iter 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 📈 o Specify: þ 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+)
URAS Elementary/Secondary (0-12) Baltimore, Maryland 17. Father's Name (First, Middle, Last, 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition Department of H Important: If Ite any injury or of once. Surial 2 Cremation 3 Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses augus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final bral ANEU **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit ner that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 No 2□/No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No P 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🕽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 25, 2004 UMPS P17933 EleNa 6: 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SON Boulvard. Raven Baltimore Loch 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 2 9 2004 Registrar

2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural", or Ite Pages 1

Stairs, Ashley

certificate be executed use as the burial-transit Box 68760, attending physician the Ś

Division of Vital Records, P.O. certificate has To the Hospital or Attending Physicien: After this eral death. Director: filled in by after 24 hours a npletely To the

State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #19a PER INF C839 47 163465 of Peath 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Ashley Joseph Stairs 6:20 PM 25,200t /Medical November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Franklin Square Hospital Rosedue
If Under 1 Year | If Under 24 Hrs. Center Baltimore 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) NOV • 27 , 1927 Birthplace (State or Foreign Country) Days Hours 1**⊠**M 2□F Months 76 219 22 5099 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Nedical Examinar must be notified at 10d. Inside City Limits Director Maryland Baltimore Middle River 1 ☐ Yes 2 No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 3303 Gentian Lane 21220 **USA** Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 XYes 2 No If Yes, Give WW II Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) à Wood Worker Lumber Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Stairs ပ္ Margaret Spurriel 19a. Informant's Name/Relationship (Type, Print)
Mary Jane Stairs (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai <u>once</u>. 3303 Gentian Lane Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 11/29/2004 Baltimore, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 21. Signaryre of Funeral Service Licensee 22. Name and Address, of Eacility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Ma. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a cardiac arrhythm, /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last arteri Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown Completed 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1DYYes 2□No Hospital: 2 2 ER/Outpatient 1 🗌 Inpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 Bukerite 9000 Franklin Square Drive Britimore, MD 21237 HNOTELL 31. Date filed (Month, Day, Year) NOV 2 State 2 9 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

			1 _ State		artment of Health and Mertificate of Death		211111111111111111111111111111111111111	37512
			Registrar  1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia /Medic		Leisha L	). Strawa		November 2		1654 p <sup>™</sup>
	Examin	er	4a. Facility Name (If not institution, give stre Northwest Hospital	et and number)	4b. City, Town, or Location of Death Randallstown		lc. County of Death Baltimore	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.     Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Aug . 7	9. Birthplac	e (State or Foreign
	Director		Usual Residence of Decedent	43 Yrs.		Hug. 7, 1	961 181ar	yland
	aryland show	_	10a. State 10b. County	10c. City, Town or L			10d	. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	recto	mb Baltimore  10e. Street and Number	e Randal	S TOWA 10f. Zip Code	10g. C	Ditizen of What Country	
	23a or	Funerai Director	3548 Carriage	Hill Circle #20	2 21133	us		
	Itams Iret	une	. II Markar otates	Was Decedent Ever in U.S. 13. Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - American Black, White, etc	
21215-0036	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show likal Examinat rust be mailfied at	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Blac	K
15-(	in 72 h "natu kolical	Completed	15. Decedent's Educati (Specify only highest grade of	ompleted) (Giv-	edent's Usual Occupation e kind of work done during most of workir DO NOT use retired)	ng 16b.	Kind of Business/Indus	stry
212	ed within giene. er than "	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	ne maker	Ho	ome	
and	t be filed ntal Hygi ed other event, I	To Be (	17. Father's Name (First, Middle, Last)			Collins	,	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 Is marked other than "natural; or Itams 23a or 28a-f show minportant: If time 27 Is marked other than "natural; or Itams 20a or 28a-f show any injury or other traumatic event, the Macifiel Examinational be nutilised at once.	ř	Jack Strawder 19a. Informant's Name/Relationship (Type,	Print) 19b. Mail	ing Address (Street and Number of Rura			ode)
	and 2 lealth a m 27 lt		Denise Chappell	- Sister 427	E. 23rd St.	Balto m	D 21218	
nore	ages 1 int of H t: If ite y or ot		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem  4 ☐ Donation 5 ☐ Other (Specify)	oval from State	ematory or other place)	194111	Location - City or Town	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature Juneral Service Lice		2. Name and A dress of Facility	o4 Car	unsville, It	1D _21229
8	8958		Jary A. Il land	G	ary P. March Funeral Hor	ne 270 Fres		alto, mo
	District Control		23a. Part. Enter the disease, or complicat shock, or heart failure. List only one of immediate Gause (Final				In O	pproximate terval Between nset and Death
	/Medical		disease or fondition resulting in death)	Due to (or as a consequence of):	PENAL DISC	5N7C		
*	Examiner	-	Sequentially list conditions, b if any, leading to immediate	Due to (or as a consequence of):				
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	Day to (e. ao a cantoquonido di).				
60,	ficate be executed physician and is the burial-transit	ai Exa	resulting in death) Last	Due to (or as a consequence of):				
68760,	± 00 %	edicai	d		170-470-			
Вох	death certifi e attending p d for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnancy 1□Live birth 2□Fetal death 3	□Ectopic pregnancy		23d. Date of delivery Month Da	ıv Year
0.	0 0 0	ıysici	1 Ses 2 No 9 Unknown	4☐ Pregnant at time of death 5 9☐ Unknown	Other (specify)		MOINT Da	ly real
4	res that igned b	by Pr	Part II. Other significant conditions contrib	uting to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the c	cause of death?
Records,	The law requires that the tee has been signed by thoage 2 should be detached.					1 ☐ Yes	2 ☐No 3 ☐ Probabl	y 4 DUnknown
Rec	The law cate has t page 2 s	Completed				24a. Was an autopsy performed?	death?	etion of cause of
		BeCc	25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	lo 1 Yes 2	□ No
of Vital	Phys this ral di	2	1 X Yes 2 □ No Hosp	oital: 1 ☐ Inpatient <b>2</b> €☐ ER/Outpatie 28a. Date of Injury		ne 5 Residence	6 □Other (Specify)	
ion	Attending I r death. actor: After by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	of 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	od. Describe flow inj	ury occurred	
Division	or Atte fter de: jiracto in by th	rtific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	8f. Location (Street a City or Town, Sta	and Number or Rural Re	oute Number,
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Diractor: completely filled in by the	ai Ce	29a. Certifier 1 ☐ Certifying Physici.	an: To the best of my knowledge, dea	th occurred at the time, date and place, a	nd due to the cause(	s) and manner as state	d.
	To the Ho within 24 h To the Fu completely	edicai	(Check only 2 Medical Examiner one)	On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date ar	nd place, and due to the	e cause(s)
	To To	Ž	29b. Signature and title of certifier	elle all too	29c. License number  OCME		ate signed (Month, Day ember 25, 2	
	h		30. Name and address of person who comp	leted cause of death (Item 23a) (Type	Print\			
	/		MANY PUTS A  31 Date filled (Month, Day, Year)	KORFIL	111 Penn Street,	, Daltillor	e, marytano	1 21201
	Sta	te ar	NOV 2 9 2004	32. Registrar's Signature	sports			

			For	State of Marylan	id / Depa	artment (	of Health a	and Me	ental Hy	gien	e	
			1 - State Registrar		Cei	rtificate	of Death				2004	37513
	Physici	an	Decedent's Name (First, Middle, Last)	_					<ol><li>Date of De Month</li></ol>	Da	y Yeer	3. Time of Death
	/Medi		Constan		Smi				ovemb	$\overline{}$	23,2004	9:10P
Ì	Examir	ner	4a. Fecility Name (If not institution, give a 8830 Piney Bra:		105		wn, or Location of				c. County of Death	× * *
			5. Social Security Number 6. Sec			If Under 1		_	8 Date of Bir	- 1	ontgome	-
	Funeral Director			M 2DXF 61	Yrs.		Pays Hours	Min.	8. Date of Bir (Month, Da Dec • 8	y, Year	942 Vir	place (State or Foreigntry) ginia
	Maryland	tor	Maryland McIntgo		y, Town or Lo		g					1 ☐ Yes 2 No
	th with the 23e or 28	al Director	10e. Street and Number 8830 Piney Bran	ch Road #11	05	10f. Zip Co 2090				10g. Ci	itizen of What Cou SA	ntry?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other then "natural", or items 23e or 28e-f show other traumatic event, the Medical Examinat must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U. Armed Forces? 1			t of Hispanic Ori Cuban, Mexicar No Specify:		ify Yes or No ican, etc.)	-	14. Race - Americ Black, White, Specify: B1a	etc.
215-0	thin 72 ho le. isn "natur i Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give		fone during mos etired)	t of working	7	Uni	Gind of Business/In ified dustries	
Maryland 21215-0036	d be filed within antal Hygiene.	To Be Con	17. Father's Name (First, Middle, Last)	nes Sr.	Supe	rviso	18. Mothe		First, Middle,	Maidei		<b>.</b>
Maryi	nd 2 should be 1 Ith and Mental I 27 is marked of traumatic eve	ř	19a. Informant's Name/Relationship (Ty.) Antoine Smith-S			-					or Town, State, Zip	
Baltimore,	Pages 1 and 2 nent of Health int: if Item 27 iry or other tra		20a. Method of Disposition		Place of Dispo emetery, cren dar G	natory or other	cem. 1	Da			ocation - City or To	
Balti	permit. Pages Department of Important: If It any injury or once		21. Signature of Funeral Service License	alung.	l C	hinn	ddress of Facility Funera Shirli	1 Se	rvice n Rd.	Arl	L.Va.22	206
	Pnysician		23a. Part1. Enter the diseese, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death e cause on each line.		er the mode o		cardiac or	respiratory er		e	Approximate Interval Between Onset and Death
760,	Medical  Westign and physician and physician and physician in physician and physician in physician and physician a	lical Examiner	Sequentially list conditions, and less in the immediate cause. Enter Underfund Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a consequence to for a co	uence of							
P.O. Box 68	The law requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregr Other (specia					23d. Date of delive Month	nry Day Year
	quires that n signed b	þ	Part II. Other significant conditions con	tributing to death but not resu	alting in the ur	nderlying caus	e given in Part I.			bacco (	use contribute to th	1
Vital Records,		Completed							24a. Was autop perfor 1 🗆 Yes		prior to cor death?	osy findings available npletion of cause of 2 No
Ë	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:					Check only o			
o	ding Phys n. After this funeral di	on: To	126 2 No  27. Manner of Death 12 Natural 5 Pending	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c.	Other: 4 Nu Injury at Work?	28	d. Describe h		6 □Other (Specify ry occurred	")
-	or Attender ter deatl irector: n by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		M eet, factory, of	1 ☐ Yes 2 ☐ I		f. Location (S City or Tow	treet an n, State	nd Number or Rura. 9)	l Route Number,
	To the Hospital of within 24 hours at To the Funerel D completely filled in	ledical C	29 Certifier 1 Certifying Phys (Check only one) 1 Madical Examin	ician: To the best of my know ar: On the basis of examinat and mariner stated.	wledge, death tion and/or inv	occurred at the estigation, in	ne time, date and my opinion, deat	d place, an th occurred	d due to the d at the time, d	ause(s)	and manner as st d place, and due to	ated. the cause(s)
	To the To the comp	M	29b. Storature and title of centrier	a Kerm	DME		cense number	28		29d. Da	te signed (Month, L	
	a		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, f	Print) 2/1	21 mx	dica	J Pa	rk	. Dr	
	Sta	te	IRA N BRECH 31. Date filed (Month, Day, Year)	22. Registrar's Signal		2110	er Spi	nn	1, 27	10	2090	7
	Registr		NOV 2.4 2004	Kendy K	Local	8						

Please Type or Print in Black Indelible Ink	Ensure All Copies Are Legible
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State of Maryland / Department of Health and Mental Hygien 🔑 🕦 📙 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death (FRUNA Year **Physician** JOJEPH 5R 11:56P M 11/24/ 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A V.A. Baltimore Rehab. Extended Care Baltimore | Salt Initial | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. | 600 | 1924, Year | 1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**□ M 2□ F 80 Ohio Yrs. Director 271-20-6623 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ar than "natural", or itams 23a or 28a-f show the Modical Examinat must be notified at 1 ☐ Yes 2 ☑ No MD Director Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3722 Courtleigh Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 TYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1□Yes Ž No Specify: White Specify: 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if I tem 27 ia marked othar than "na any Injury or othar traumatic evant, II to M. Cit. 2008. Elementary/Secondary (0-12) College (1-4or 5+) Route Salesman Baking 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph F. Serwna Eleanor Klinker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph B. Serwna, Jr, 164 Ridge Road, Jupiter, FL. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD. 21784 Lake View Memorial Pk 11/27/04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors 8728 Liberty Road, Randallstown, MD. 21133-4784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed ate has been signed by the attending physicisn and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of deliver. 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ es 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of Injury ne Hospital or Attanding Pl n 24 hours after death. na Funaral Director: After ti 27. Manner of Death 28d. Describe how injury occurred Certification: 1 SMatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 To tha I 29b. Signature and title of certifier 047804 11/24/8004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD EIZIX 3900 WCH RAVEN BLUD A MROWIEC 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar Temas

DHMH 17 Rev 1/2001

A.M.

5:45

VOVEMBER

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			For State Registrar	State of Marylan		artment of H			2004	37516
	Physici		1. Decedent's Name (First, Middle, I	·				2. Date of Death Month	Day 2004	3. Time of Death 9:30AM M
	/Medic Examin	al	LEATRICE LORRAI  4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Death	Nov. 2	4c. County of Deat	
	Examin	er	9237 Smith Aven				e County		Baltimo:	
	Funeral Director		5. Social Security Number 6 212-22-6804	. Sex 7. Age (In yrs. 1 ☐ M 2 🗡 F	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y		hplace (State or Foreign buntry)
	ס		Usual Residence of Decedent					0ct. 26,1	924 Ma:	ryland
	Marylan a-f ahow Iffed at	tor	10a. State 10b. County  Maryland Baltim		ty, Town or Lo		re County			10d. Inside City Limits 1 ☐ Yes 2 📉 No
	ith the	Direc	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
	eath w	erai	9237 Smith Aven	12. Was Decedent Ever in U	.S. 13.	2123			USA 14. Race - Ame	nican Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic avant, the M. of tal Examination and Demonstrated at another.	by Funerai Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 <b>X</b> XNo	n, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
21215-0036	72 hou natura	ted	15. Decedent's	Education	16a. Dece	dent's Usual Occupa	ation	ing 16	b. Kind of Business/	Industry
121	ne. han "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired ewife	i)		ousokooni	ng-Own Home
d 2	filed v Hygie othar t		9 yrs. 17. Father's Name (First, Middle, La	N/A	HOUS	ewtre	18. Mother's Nam	e (First, Middle, Ma		ng~own nome
/lan	uld be Wental Irkad c	To Be	Harry Joseph Ta	gg			Evelyn	Mary Ship	ley	
Maryland	12 sho h and 1 is me reume		19a. Informant's Name/Relationship						City or Town, State, 2	Ip Code)
ē,	Healt Healt tam 2		Yvonne M. Simon 20a. Method of Disposition	20b. F		Smith Aversition (Name of matory or other place			c. Location - City or	Town, State
E	Pages nent of int: If i		1 Burial 2 □ Cremation 3 1 Donation 5 □ Other (Spe	Hemoval nom State		f Faith	1129	04 Ba	ltimore,	Md.
Baltimore,	permit. Departn Imports any inju		21. Signature of Funeral Service Lic	on Charack	L	2. Name and Addres assahn Fu 401 Relai	neral Ho	me ltimore	Md. 21236	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the deat						Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	- MUOCARO	AL	INFARC	7102			Suddle
	/Medical Examiner		resulting in dealin)	Due to (or as a conseq	quence of):					
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	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	ruonno of):					
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687	tificate ng phy: as the	ed	No person p	u.						
Вох	eath certific attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 manths?	23c. If yes, outcome of pregna	al death 3	Ectopic pregnancy			23d. Date of del	ivery Day Year
P.O.	that the de ed by the a detached t	ysic	in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	4□ Pregnant at time of d 9□ Unknown	beath 5	Other (specify)				
	Se g	by	Part II. Other significant condition HUDERTENSIO	1	sulting in the u	nderlying cause give	en in Part I.	23e. Did toba	1/	the cause of death?
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I Re		Com				,		autopsy performe 1 Tes 2	d? death? 1 ☐ Yes	completion of cause of
Vita	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe		h (Check only one)		
of	ding Physin.  After this of tuneral directory.	n: To	1 ☐ Yes 2 12 No  27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe how	ce 6 Other (Specinjury occurred	zify)
ion	Attending or death.  actor: After by the fune	atio	1 Natural 5 Pending 2 Accident investiga	tion	Injury		K? Yes 2 □ No			
Division	in Dirt	Certification:	3 Suicide 6 Could no 4 Homicide determin		ome, farm, st fy)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	iral Route Number,
	Hospita 4 hours Funaral	Medicai C		Physician: To the best of my kno kaminer: On the basis of examina and manner stated.						
	To the within 2 To tha complet	M	29b. Signature and title of certifier	In wo		29c. License	e number )433		Date signed (Month	1, Day, Year)
•	V		30. Name and address of person w	no completed cause of death (Iter	m 23a) (Type,			RMTIM	DRA M	22204
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature 4	Som V	5/	7,0,1,0	/ · · · · ·	9 21204
	Regist	all	NOV 2 9 2	1004		Jan Caro	<b>.</b>			

			1 - For State Registrar	State of	Maryland / Dep	ertment of Fertificate of			giene 004	37517
	<b>D</b> I		Decedent's Name (First, Middle,	Last)			_	2. Date of Dea		3. Time of Death
	Physici /Medio		Joseph John Si					Novembe	er 23, 200	4 3:15P M
	Examin	er	4a. Facility Name (If not institution,	-			or Location of Dea	ath	4c. County of De	
	<b>-</b>		5630 Wisconsin		APT。 # IUZ 7. Age (In yrs. last birthday	Chevy Ch		rs. 8. Date of Birt.	Montgom	
	Funeral Director		346-09-5426	1XM 2□F	85 Yrs.	Months Days	Hours Mi		, 1919 I	Birthplace (State or Foreign Country) 11inois
	pu ,		Usual Residence of Decedent		100 Cir. T					
	shov	or.	10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits 1 1√2 Yes 2 □ No
	289-f	rect	Maryland Montgo	omery	Chevy C	10f. Zip Code			10g. Citizen of What	21
	3e or	١	5630 Wisconsin	Avenue. A	nt.#102	20815			United St	•
	death	Funeral Director	11. Marital Status			Was Decedent of H	Hispanic Origin?	(Specify Yes or No-	14. Race - A	merican Indian,
36	or Ite	y Fu	1 ☐ Never Married 2 ☐ Marrie	d 1 √ Yes :	<sup>2□No</sup> World	1 ☐ Yes 2 ☐ No		onto i noun, etc.)	Black, W Specify:	rite, etc.
Ö	72 hours after death with the Maryland natural, or items 23e or 28e-f show dical Examiner must be notified at	ed by	3 X Widowed 4 ☐ Divorced	Year or Da	tes: War II	edent's Usual Occup	nation		16b. Kind of Busine	White
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nd	be file tal Hy d oth	To Be (	17. Father's Name (First, Middle, L.	ast)				ame (First, Middle,	·	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28e-f show any injury or other treumetic event, the Macical Evantmet must be notified at once.		19a. Informant's Name/Relationshi Carol B. Sisco.			ing Address <i>(Street</i> 2. Parkviet			or, City or Town, State	9, Zip Code) 1140–1017
ē,	Heal Heal tem 2 other		20a. Method of Disposition		20b. Place of Disp	osition (Name of		Date	20c. Location - City	
Ë	Page ient of nt: If ry or		1 ☐ Burial 2 ②Cremation 3  1 ☐ Donation 5 ☐ Other (Spe		<sup>tate</sup>   Montgome	ematory or other place ry rium, Inc.	100	mber 2004	Bethesda,	Maryland
a	permit. Departmine importe any inju		21. Signature of Funeral Service Li	o poe	GI CING CO	2. Name and Addre			umphrey F	uneral Home/
<u>-</u>	8978		3 Gride	. Tem	. моовоз <mark>I</mark>	Bethesda,	Marylan	d 20814-	-3501 Wis	uneral Home/ consin Avenue
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8760,	rcate be executed physician and s the burial-transit	E	resulting in death) Last	Due to (c	or as a consequence of):					
687	physics the k	Physician/Medical		d.						
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	death	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregna	nt at time of death 5	□Ectopic pregnancy □ Other (specify) _	/		Month	Day Year
P.O.	that the de led by the a detached f	Phys	9 Dunknown	9□ Unknov				100.00		
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of Vital Records,	w requir been si should	Completed								
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Ž	yslcie is cer direct	To Be	examiner? 1 ☐ Yes 2 🃉 No	Hospital: 1 ☐ In	patient 2 ER/Outpatie	ont 3 DOA Oth			ence 6 Other (S)	pecify)
0 0	Attending Physicien: ir death. ector: After this certific by the funeral director.		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of (Month	Injury 28b. Time	of 28c. Injur	y at	28d. Describe h	ow injury occurred	
Sio	tandi death. tor: A the fu	catl	2 Accident investigated investigated Accident investigated and investigated Accident Accident investigated Accident	t he			Yes 2 □ No	00( 11 (0		
Division	after of Direction by	Certification:	4 ☐ Homicide determin	ed 286. Place	of Injury - At home, farm, s g, etc. <i>(Specily)</i>	treet, factory, office		City or Tow	treet and Number or in, State)	Rural Route Number,
	e Hospitel or Attand 24 hours after death Funerel Director: etely filled in by the i		29a. Certifier 1 Certifying	Physician: To the t	pest of my knowledge, dea	th occurred at the tir	me, date and place	ce, and due to the o	ause(s) and manner	as stated.
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical E	kaminer: On the bas and mann	sis of examination and/or i	nvestigation, in my o	pinion, death occ	curred at the time, o	date and place, and d	ue to the cause(s)
	with To t	Σ	29b. Signature and title of certifier	A. 1/2.41	MS EARL	29c. Licens	e number	2	29d. Date signed (Mo	nth, Day, Year)
	N		1/1/	7-00/14	THE FACE	D142	.53		November 2	23, 2004
	251		30. Name and add so of person w Marjorie A. Voi		of death (Item 23a) (Type 2702 Parkvi		Rivo	Marvland	211/0_10	17
	Sta	te	31. Date filed (Month, Day, Year)		gistrar's Signafure	1 4	, MIVa,	riarytaiid	21140-10	1/
	Registr		NOV 2 9 2004	Bener	a B St	sounds!				

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	Reg. 878. 004	37518
	Dhusisian	Decedent's Neme (First, Middle, Last)	2	2. Dete of Death Month Dey Year	3. Time of Death
н	Physician /Medical	VIRGINIA SOUTHC	OMB	NOV. 26, 2004	3:20 AM
	Examiner	4e Fecility Neme (If not institution, give street end number)	4b. City, Town, or Loca	ation of Death 4c. County of Dee	th
		ST. CATHERINE'S NURSING CENTER	EMMITSBURG		
п	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. lest b	Months Days Hours Min.	B. Date of Birth (Month, Day, Year) 9. Birth Co	thplace (State or Foreign ountry)
	Director	577-05-9488 86  Usuel Residence of Decedent	E	AUG. 28,1918   Mar	yland
	ylend		wn or Location		10d. Inside City Limits
	Mer de la	PA Adams Fair	field		1 ☐ Yes 2 ☑ No
	or 28	10e. Street end Number	10f. Zip Code	10g. Citizen of What Co	ountry?
	23a 23a rai	235 Franklin Street	17320	United St	ates
	ifier death with the Mei r items 23a or 28a-f si infer must be notified Funeral Director	11. Maritel Status  12. Was Decedent Ever in U,S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri</li> </ol>	ify Yes or No- ican, etc.) 14. Race - Ame Black, Whit	
Maryland 21215-0036	by by	3 ¼ Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 反 No Specify:	Specify: Wh	ite
5-0	ed within 72 ho ygiene. Tr. the Medical ft, the Medical	15. Decedent's Education (Specify only highest grade completed)	e. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business/	/Industry
21	ithin nen.	Elementery/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		
7	Part Co	12 17. Father's Name (First, Middle, Last)	Homemaker	Own Home	
auc	D edab		,	rah Melissa Mor	ris
2	12 should be filed within n end Mental Hygiene. 1e marked other than raumatic event, the Marantatic event, the		b. Mailing Address (Street and Number or Rurel F		
Z	s 1 end 2 should f Health end Mer tem 27 le marke other traumatic		026 Noble Oak Drive, Ge	•	
ē,	f Head	20a. Method of Disposition 20b. Place		Date 20c. Location - City or	
Baltimore,	permit. Peges 1 and 2 s Department of Health er Important: If Item 27 le eny injury or other trau once.			, 2004 Bethesda, N	Marvland
alti	y Inju	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Rober Rockville, Inc. 300 V		
<b>m</b>	8258	FORR MO1356	Rockville, Inc. 300 v	vest montgomery A 20850-2805	venue
		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or r	espiratory arrest,	Approximate Interval Between
	Physician			1	Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	SCHEMIC STROKE		
	je je		e consequence of):	1	
	executed on end nel-trensit Examiner	b			
ó	the deeth certificate be executed y the ettending physicien end sched for use as the bunel-trensit hysician/Medical Examir	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	consequence of):		
68760,	iysicii nysicii ne bu		consequence of):		
39 ×	entificete be ling physicie ie es the bu	resulting in deetil) Last			
Bo	eeth ce ettendi I for us clan/	d			
0	d by the ettend eteched for us	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23b. Did tobacco use contribute	to the cause of death?
Ω.	thet the de led by the e deteched i			1 ☐ Yes 2 ☐ No 3 ☐ Pr	robably 41 Unknown
Records,	8 <u>P</u> Q			24a. Wes an autopsy 24b. V	Were autopsy findings
8	The law require sete has been signate has been signage 2 should to Completed			performed?	available prior to completion of cause of deeth?
æ	The law ete hes b page 2 s				1 □ Yes 2 □ No
Vital	certificate rector, pag	25. Was case referred to medical	26. Plece of Death (0		12100 22100
of <	\$ 50 E	examiner? 1 ☐ Yes 2 No  Hospital: 1 ☐ Inpatient 2 ☐ ER/O	outpetient 3 DOA Other: 4 Nursing Home	5 Residence 6 Other (Spec	cify)
	fter thunered		Injury Work?	d. Describe how injury occurred	
SiO	Attending or deeth.  octor: Afte by the fune	2 ☐ Accident investigation	M 1 Yes 2 No		
Division	lal or Attending Pis effer death.  Is offer death.  In Director: After tied in by the funere Certification:	4 Homicide determined 28e. Plece of Injury - At home, fi building, etc. (Specify)	arm, street, factory, office	f. Location (Street and Number or Ru City or Town, State)	iral Houte Number,
_	Hospital 24 hours Funeral stely filled	29a. Certifier 1X Certifying Physician: To the best of my knowledg	e, deeth occurred at the time, date and place, and	d due to the cause(s) and manner as	stated.
	To the Hospital or Attending Phwithin 24 hours efter death. To the Furerel Director: After th completely filled in by the funeral Medical Certification;	(Check only one) 2 Medical Examiner: On the basis of examination early and menner stated.		at the time, date and place, and due	to the cause(s)
	within 2 To the comple	29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month	h, Day, Year)
)	.6	m A	10 D 58391	NOVEMBER 26,	, 2004
	()	30. Name and eddress of person who completed ceuse of death (Item 23e)			
	Ctoto	SAJJAD AZIZ, M.D. 801 TOLL HOU  31. Dete filed (Month, Day, Yeer)  32. Registrer's Signeture	JSE AVE, FREDERICK, MD.	21701	
	State Registrar	NOV 2 9 2004 Shaw	& Sports		
		TOY NO LUUT	page or whole		

DHMH 16 Rev 6/95

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygieze 0 4 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** SPRINGER EUGIENE 6:00 18 NOVEMBER 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Future Care Nursing Home Baltimore N/A 8. Date of Birth (Month, Day, Year) NOV 21, If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** Months 1 XM 2 ☐ F 89 212-01-7049 1914 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

The filem 27 is marked other than "neturel", or items 23a or 28a-1 show the function of the filem 20 is marked other than "neturel", or items 23a or 28a-1 show the the file of the filems of the file of the filems 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ▼No Maryland Howard Elkridge Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6005 Rowanberry Dr. 21075 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No 1942 − If Yes, Give Year or Dates: 1944 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No White Baltimore, Maryland 21215-0036 Specify: Specify: 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Record Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eugene Ridgley Springer Mary Bertha Boswell ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is ary injury or other trai David F. Mayne, nephew 6005 Rowanberry Dr. Elkridge, MD. 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Bayview Crematory //- 2 v - 0 4 Baltimore, MD □Donation 5 □ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD.21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Heypurten son year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Costonava Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Certification: To Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed Facial Carrinema Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day detached for Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 ☐ Unknown á Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 No 1 Yes or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other. 4 Sursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation after death. 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiei Medicai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Thankon, MD, FACP D 57088 NOVEMBER 19, 2004, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Paul Place # 701. Baltimore WD 31303 31. Date filed (Month, 32. Registra's Signature State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene, 37520 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 2004 Bernice Genevive Sprecher November 14:50 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Locetion of Death 4c. County of Death Examiner Avalon Manor Health Care Center Hagerstown Washington If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer)
January 2,1917 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Funeral Months Days 1□M 2X0 F 87 Yrs 207-12-8960 Director New Jersey Usual Residence of Decedent filed within 72 hours efter death with the Marylend 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1314 Oak Hill Avenue 21742 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 🕽 ☐ No Specify: Specify: White þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill timent of Health and Mentel H tent: If Item 27 is marked out Be Peter Walsh Wigalesworth Abidail Genevive Tavlor 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Department of Health a important: If Item 27 is eny injury or other tree 12121 Pawnee Drive, Gaithersburg, Maryland 20878 Peter A. Sprecher Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Hagerstown Crematory 11-24-04 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Maryland 2174 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of sech line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) nvicaical Arterio Schendere Cardio Vana Examiner Due to (or as a consequence of): Physician/Medical Examiner ettending physician end for use es the buriel-transit or Attending Physicien: The law requires thet the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? when minen completion of cause of death? TLIYUS 2LENO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 D Norsing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 ☐ Yes 2 ☐ No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 ONatural 5 Pending efter deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident te Hospital or Atter n 24 hours efter der ne Funeral Director pletely filled in by th 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as steted. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted. To the To the To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 218019 NOV 24, 2004 -terest MD 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) MO 21740 57 HAGERSTOWN MILL DATTO MO 340 VASANT 31. Dete filed (Month, Day, Xeer) 4 32. Registrer's Signature

DHMH 16 Rev 6/95

Registrar

1 \_ State

State of Maryland / Department of Health and Mental Hygien 004

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		* Hegistrar			runcate of Death		Reg. No.	
Phys	ician	1. Decedent's Name (First, Middle, L Laura Agne	,			2. Date of D Month	Day	3. Time of Death
I	dical	4a. Facility Name (If not institution, g			4b. City, Town, or Location		ber 22, 2	
Exan	niner	Carroll Hospita	·		Westminst			arroll
Funer	al	Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthday	If Under 1 Year If Under	r 24 Hrs. 8. Date of B	lirth	9. Birthplace (State or Foreig
Directo		219-01-6319	1□M 20F	93 Yrs.	Months Days Hours	Min. Month, Dec 1	6, 1910	Maryland
pg \star		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	and in			404 1-14 00 11 1
sho	5		-011	Toc. Oily, Town of E		minster		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M	Director	10e. Street and Number	OII	<u> </u>	10f. Zip Code	minster —	10g. Citizen of W	•
with page 1			ircle apt 5	508	2115	8		SA
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. thygiene. ships then "natural", or Items 23a or 28e-1 show ent, the Medical Examinat must be notified at	Funeral	11. Marital Status	12. Was Decedent		Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica			- American Indian,
6 after o	Fu	1 X Never Married 2 ☐ Married		No				k, White, etc.
ours a	λq p	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2√∑ No Specify	:	Specify:	white
72 h	Completed	15. Decedent's (Specify only highest g	Education rade completed)	(Give	dent's Usual Occupation kind of work done during mos	st of working	16b. Kind of Bus	siness/Industry
Mithin Mithin	dm	Elementary/Secondary (0-12)	College (1-4or	5+) life.	Analyst		Balti	more City
Hygie ht.			it)			er's Name (First, Middl		<del>-</del>
d be antal ked o	To Be	Charalan D III-				ary Martin	of marcon our and	•/
Maryland 21215-0036 nd 2 should be filed within 72 hours aft the and Mental Hygiene.  27 Is marked other then "natural", or treumatic event, the Medical Exami	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ng Address (Street and Numb		ber, City or Town, S	State, Zip Code)
IOFE, Maryland 21215-0036  ges 1 and 2 should be filed within 72 hours after death with the Marylan to t Health and Mental Hygiene.  If item 27 is marked other then "natural", or Items 23a or 28e-1 show or other treumatic event, the Medical Examination in the health at		Charles Tawney,	brother	165	41 Trenton Ro	ad, Upperco	, MD 211:	55
of He fitem		20a. Method of Disposition 1X Burial 2 □ Cremation 3	Damaval from State	20b. Place of Disp cemetery, cre	matory or other place)	Date	20c. Location - 0	City or Town, State
Pag ment ant: h	1	'4 □Donation 5 □Other (Spec		Christ :	Lutheran Cem.	11/24/2004	Uppe	rco, MD
Baltimore, I permit. Pages 1 and Department of Healt Important: If item 2 any injury or other	- BOCG	21. Signature of Fulleral Service Lice	MO MO	0 /23	2. Name and Address of Facil	ity Eline l	Funeral H	ome
	a	shever	UC.	luci	934 South Mai			
Marie II		23a. Part1. Enter the disease, or co- shock, or heart failure. List only	y one cause on each li	ne.	ter the mode of dying, such as	s cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
Physicia /Medica		Immediate Cause (Final disease or condition resulting in death)			EART FAIL	URE		3 DAYS
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	ē 🌃	Sequentially list conditions,	b. ACUT	a consequence off.	HOED MYOU	ARDIAL	IN FARC	TION 40473
uted b	Examiner	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	PERF	ORATED	DIVERTICAL	TIL FRO	27 3161	MOD) 5 DAYS
O, exec an an rial-tr		resulting in death) Last	Due to (or as	a consequence of):				
Box 68760,	an/Medical		d					
r 68 ntiffica ng ph	Med	IF FEMALE:						
30) ath ce ttendi	lan/	23b. Was decedent pregnant in the past 12,months?		2 Fetal death 3	Ectopic pregnancy		23d. Date Mon	of delivery th Day Year
O. In the dear of	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of death 5	Other (specify)		IVIOIT	th Day Year
that if	Physici	Part II. Other significant conditions	contributing to death b	ut not resulting in the t	inderlying cause given in Part	1 23e Did	tobacco use contril	oute to the cause of death?
ds, uires uires i signe	Completed by	Chironic Obs	tructive	Pulmon			Yes 2 □ No	3 Probably 4 □Unknown
cord w require been sig	ete					24a. Wa:	94h W	are autoscy findings available
Re he la e has	d H					auto	opsy pr formed? de	ere autopsy findings available ior to completion of cause of eath?
tai nr. T ifficati or, pë	CC	25. Was case referred to medical	T		26 Place	1 Yes		Yes 2 No
ysicie s cert	To B	examiner?	Hospital:	ent 2 ER/Outpatie	Oth	e of Death (Check only ursing Home 5 🗀 Res	-	(Specify)
g Phy gerthi		27. Manner of Death	28a. Date of Inju				how injury occurre	
ath.	atio	1 XNatural 5 Pending 2 Accident investigati	on	y rear/ irijury	M 1 Yes 2	No		
Division of Vital Records, for Attending Physicien: The law requires the death.  Director: After this certificate has been signed in by the funeral director, page 2 should be a	Certification:	3 Suicide 6 Could not determine	d 286. Place of inj	ury - At home, farm, st c. (Specify)	reet, factory, office	28f. Location City or To	(Street and Number	r or Rural Route Number,
Dittel o								
Hosp 4 hou Fune	edical	(Check only 2   Medical Exa	iminer: On the basis o	f examination and/or ir	h occurred at the time, date ar vestigation, in my opinion, dea	nd place, and due to the ath occurred at the time,	a cause(s) and man , date and place, ar	ner as stated. nd due to the cause(s)
DIVISION Of VITAI Re- To the Hospitel or Attending Physicien: The lawithin 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Med	29b. Signature and title of certifier	and manner st	ated.	29c. License number			(Month, Day, Year)
¥ × × 8		and the of certifier	Lauren	mo	360189	7-74		
		30 Name and address of names in	completed acres of	loath (Itom 33c) (Time	Print\	10	ON MELAN	22, 2004 RIAL AVE.
10		30. Name and address of person who	RONG SU	PHAVE J	KORNKIJ M			ER, MD 21157
	State	31. Date filed (Month, Day, Year)		ar's Signature		•	25/19/10/05/	CA, 100 2113

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

			1 = For State Registrar	State of Ma		partment of F	Health and M Death	ental Hygie	711114	37522
	Physici /Medic	al	Decedent's Name (First, Middle, Last     A. Facility Name (If not institution, give	WILLIAM	FREDERIC	K TRAVERS		2. Date of Death Month SCUEMB		3. Time of Death
	Examir Funeral Director	ier	NORTH ARUNDEI 5. Social Security Number 6. S	HOSPITAL	(In yrs. last birthda)	GLEN	or Location of Death  OURVEE  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day, Yo	ear) 9. Birth	UNDEL place (State or Foreign intry) ryland
	Maryland 9-f show	tor	10a. State 10b. County Maryland Anne Ar		10c. City, Town or I		asadena			10d. Inside City Limits 1 ☐ Yes 2 No
4	ath with the 23e or 28e	ral Director	10e. Street and Number 7934	Liberty Ci	rcle	10f. Zip Code	2112	2	. Citizen of What Cou USA	intry?
וררו ש W	a within 72 hours after death with the Maryland jiene. r then "neturel", or Items 23e or 28e-f show the Madical Examinat must be notified at	Completed by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ X Widowed 4 □ Divorced	12. Was Decedent E- Armed Forces? 1 Tyes 2 Tho If Yes, Give Year or Dates:	ver in U.S. 13	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ※ No	dispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
ارار 1215-0	s within liene. r then "	ompietec	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+	(Giv	edent's Usual Occup e kind of work done DO NOT use retired Machinist	during most of workir d)	ng	b. Kind of Business/Ir & O Railr	
AVERS, 1	be filed tal Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last)	Thomas T				n Peters		
	nd 2 lith a 27 is r treu		19a. Informant's Name/Relationship (1 Romona Lynn Trave			4 Liberty	Circle, 1	Pasadena,		22
3altimore,	t. Page rtment o rtent: If rjury or		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □  '4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service	)	Bayview	ematory or other place	, Inc. 11		altimore,	
8760,	Physician /Medical Examiner  permial-transik	edical Examiner	23a. Part L Enter the disease, or composhock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (or as a c.	he death. Do not er	McCully-F 237 E Pa	olyniak Fintapsco Average and a such as cardiac of the such as cardi	uneral Hoe., Balti	ome, P.A.	21225–1856 Approximate Interval Between Onset and Death
P.O. Box 6	that the death certifics ed by the attending ph detached for use as t	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	(		23d. Date of deliver Month	ery Day Year
ords, P	w requires that been signed b should be deta	ted by PI	Part II. Other significant conditions of	CASTLA			ren in Part I.	23e. Did tobace	co use contribute to to	. 2
Division of Vital Records,	ysicien: The law r is certificate has be director, page 2 sh							24a. Was an autopsy performed 1 ☐ Yes 2√2	prior to co death?	opsy findings available impletion of cause of
f Vit	Physicier this certif al directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient	t 2 ☐ ER/Outpatie	ont 3 DOA Oth	26. Place of Death er: 4 ☐ Nursing Hom		e 6 ⊡Other (Specif	fv)
sion o	ttending Ph death. stor: After th the funeral	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Year) 28b. Time (Injury	Wor		8d. Describe how in		
Divi	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certifi	4  Homicide determined	building, etc.				City or Town, S		
	he Hos in 24 ho he Fune pletely f	edical	29a. Certifier 1 Certifying Phyone) 1 Medical Exam	ysician: To the best of iner: On the basis of e and manner state	examination and/or it	th occurred at the tin	ne, date and place, a pinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as s and place, and due to	tated. 5 the cause(s)
	To 1 To 1	Σ	29b. Signature and title of certifier	e.h.		29c. License			Date signed (Month,	
, —	1031		30. Name and address of person who o	completed cause of dea	ath (Item 23a) (Type		) (/ 7	)	1/24/04	, ,
A	Sta Registr		31. Date filed (Month, Day, Year) 20	32. Régistrar	's Signature	Sport.	a CHEM C	ovince iv	in alla	1

			1 - For State Registrar	State of Marylan	d / Department of Health and N Certificate of Death	, ,	ene	
	Physici		Decedent's Name (First, Middle, Las	Samuel T	raunham	2. Date of Death Month	Day Year 2004	e. Tilmedif Essatu
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	4b. City Town, or Location of Death	1	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Security Number 10. Security Number 1	1. Also (In yrs. 1) 1. Als	ast birthday)  Yrs.  HOUNG If Under 1 Year  If Under 24 Hrs.  Months  Days  Hours  Min.	8. Date of Birth	ear) 9. Birth	place (State or Foreign intry)
	ith the Maryland or 28e-f ehow	jo.	10a. State 10b. County  Rolling		7, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	Direct	10e. Street and Number	) md #2	10f. Zip Code	10g	J. Citizen of What Cou	intry?
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. Item 27 ie marked other then "natural", or Items 23a or 28e-f ehow other treumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Mover Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	S. 13. Was Decedent of Hispanic Origin? (So If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	ican Indian, , etc.
21215-0036	ithin 72 hou na. "natura Medical E	Completed	15. Decedent's Edi (Specify only highest grad	cation le completed) College (1-4gr 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king [16	b. Kind of Business/Ir	ndustry
S	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the M	Be	17. Father's Name (First, Middle, Last)	N/A	Mechanic  18. Mother's Nam  Provided  18. Mother's Nam  Pr	e (First Middle, Ma	WEETNEAF iden Sumame)	+ Cup Co.
Maryland	2 should I and Meni ie marke reumatic	To	19a. Informant's Name/Relationsh	rpe, Print)	19b. Mulling Address (Street and Number or Rul	ral P <sub>au</sub> te Number, C	U [ ity or Town, State, Zi	p Code)
	of Health of Health filtem 27 i		20a. Method of Disposition  1 Burial 2 Cremation 3		lace of Disposition (Name of ametery, crematory or other place)	Date 20	c. Local on - City or T	own, State
altimore,	Pag ment ent: i		`4 □Donation 5 □Other (Specify,	BIC	OCKSBURG Cemitely 11- 22, Name an Address of Facility 11-	30-04 B	ACKSBURI	3 MD.
Ba	permit. Departr Importe any inj		> Vaughn C. O	heen	8728 Liberty Rd.	Randailo	Four My	D 21/38
	Physician /Medical		Shock, or head ailure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.				Approximate Interval Between Onset and Death
ŀ	Examiner		Sequentially list conditions,	J	BOLIC ACI,	105I	5	24 hrs.
Vit	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ				
3760,	sate be ex hysician the buria	dical E		d.	once on.			
Records, P.O. Box 68760, <	at the death certific by the attending pi tached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar  1 Live birth 2 Fetal  4 Pregnant at time of de	death 3 Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
rds, P.	quires that the signed by all be detacted	by		ntributing to death but not resu	Iting in the underlying cause given in Part I.		co use contribute to t	he cause of death?
		Completed				24a. Was an autopsy performed	prior to co death?	ppsy findings available mpletion of cause of
of Vita	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 No	Hospital: 1 <b>⊠</b> Inpatient 2 🗆 E	26. Place of Deat Cther: 4 \( \text{Nursing Ho} \)	h <i>Check onl, one</i> me 5 ☐ Residence	e 6 □Other (Specif	(y)
		atlon:	27. Manner of Death 1 SNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)		28d. Describe how i		
Division	irec irec	Certific	3  Suicide 6  Could not be 4  Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura itate)	al Route Number,
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	edical	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami	sician: To the best of my know ner: On the basis of examinati and manner stated.	viedge, death occurred at the time, date and place, ion and/or investigation, in my opinion, death occurr	and due to the caus red at the time, date	e(s) and manner as s and place, and due to	tated. o the cause(s)
)	To the within To the comp	Me	29b. Signature and title of certifier	Mmja	MD AT 24389 5		Date signed (Month,	
	2		30. Name and address of person who co					
	Sta Registr	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure	V. III		~ a1410 2010
DHM	1H 17 Rev 1/20	001		1	DRIGINAL STREET			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year 1900 novemberal 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5. Social Security Number 6. Sex 7. Age (In vrs. I. 7. Age (In yrs. last birthday) If Under 1 Year HARFORD If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) Funeral Birthplace (State or Foreign Country) Days Hours 1 □ M 25 F Months Yrs. 213 28 0012 Director MARN ZEVAS Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits itam 27 is marked other than "natural", or itams 23s or 28s-f show other treumatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director 1 Yes 2 No HARFORD ARATACO DOSWIED 3 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? LOURT 400 (locth Fiel 21040 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LADALSR 127 RS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HEARY JOHN LARIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21040 itam 27 i 20b. Place of Disposition (Name of Date 20c. Location - Cit FREATRIC 20a. Method of Disposition 20c. Location - City or Town, State Ost Date permit. Pages 1
Depertment of H
important: if its
any injury or ott 22. Name and Address of Facility 1 Burial 2 Cremation 3 Removal from State \*4 □ Donation 5 □ Other (Specify) 2004 21. Son Vinne Funeral Jervice License CHARL-BELAGER 0.4 ORIVE FOREST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** Staphalococcal sensis 6 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cirrhusis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Heanth to C autopsy performed? Fredslage Renal Failur on Dunysis 25 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: Painpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To To the Hospitel or Attanding Pt within 24 hours efter death. To the Funeral Director: After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Del Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P00048050 reshert 11/27/04/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #400

DHMH 17 Rev 1/2001

State Registrar

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**ORIGINAL** 

15 South Parke Street

32. Registrar's Signature

M.D.

Shukla

Prashant 31. Date filed (Month, Day, Year) Abesdeen mo 21001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepen 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Taylor 16: 45 PM 27, 2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dhns Social Security Number A Sex Age (In yrs. last birthday Date of Birth (Month, Day, OV, 2H, 9. Birthplace (State or Foreign **Funeral** Months 219-78-3202 Usual Residence of Decedent 1 M 2 PT Days Hours Director with the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28e-1 show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hyglene. Important: If item 27 is marked other than "rany injury or other traumatic event. The Med College (1-4or 5+) Elementary/Secondary (0-12) DISAD/E (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Sumame) Be ပ rmant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation \_ 9 ☐ Other (Specify) 21. Signature of Feneral Service Licens 23a. Part Len't me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate dise (Final disease or condition resulting in death) Przysician Hypotension week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): use as the burial-transit The law requires that the death certificate be executed that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 🗆 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ eq 1 ☐ Yes 2 XNo 3 Probably 4 | Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 2 No 2 No To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Unpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

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MOP KINS

31. Date filed (Month, Pay, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  $\forall l \in \mathcal{LI} \land A$ 

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32. Registrar's Signature

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BALTFMORE

27,2004

MARYLAND 21287

		For State	State of Man		artment of Health a			07506
		1 - State Registrar	41	Cer	tificate of Death			37526
· Physici	an	1. Decedent's Name (First, Middle, L. Walter James T	incher			2. Date of Death Month	25, 2004	3. Time of Death
/Medi		4a. Facility Name (If not institution, gi			4b. City, Town, or Location of		25, 2004 4c. County of Death	4:25 a <sup>M</sup>
Examir	er	Ivy Hall Geriatr			Middle River	Death		
Funeral		5. Social Security Number 6.	Sex 7. Age (I	(In yrs. last birthday)	If Under 1 Year If Under 2		Baltimore 9. Birthpla	ace (State or Foreign
Director		234-20-5232	1 🗷 M 2 🗆 F	91 Yrs.	Months Days Hours	July 8,	1913 West	Virginia
pu s		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Lo	cation			
Aaryle F sho	٥						10	<ul><li>d. Inside City Limits</li><li>1 ☐ Yes 2 ▼No</li></ul>
28a-i	rect	Maryland Baltimo 10e. Street and Number	re	Middle Ri	Ver	10	g. Citizen of What Count	
3s or	Funeral Directo	6 Bay Court			21220		U.S.A.	. y :
death ms 2	nera	11. Marital Status	12. Was Decedent Eve	er in U.S. 13. V	Was Decedent of Hispanic Orig f Yes, specify Cuban, Mexican,	in? (Specify Yes or No-	14. Race - America	
after or Its	F.	1 ☐ Never Married 2X Married	Armed Forces? 1   Yes 2  No If Yes, Give	1936	i res, specify Cuban, Mexican, I□Yes 2⊠No Specify:	Puerro Rican, etc.)	Black, White, e	tc.
21215-0036  d within 72 hours after death with the Maryland gjene. gren "naturel", or Itams 23s or 28s-f show than "naturel", or Itams 23s or 28s-f show the Maryland Exercite Strong the Parilliand at	d by	3 Widowed 4 Divorced	Year or Dates:	1937			Specify: Wh	ite
15-	Completed	15. Decedent's E (Specify only highest gi	Education rade completed)	(Give	lent's Usual Occupation kind of work done during most DO NOT use retired)	of working	6b. Kind of Business/Indu	ıstry
withii ene.	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		ity Guard		Aero—Space	
if filed the other went,	Be C	17. Father's Name (First, Middle, Las	st)	Decar		's Name (First, Middle, Ma		
Vlat be vled be virkad virkad titic ev	To B	James D. Tincher			Rhoo	la Helen Vass	3	
Baltimore, Maryland 21215-0036 parmit. Pages I and 2 should be filed within 72 hours after death with the Marylan parmit. Pages I and 2 should be filed within 72 hours after death with the Marylan Important: If flem 27 is marked other than "naturel; or Itams 23a or 28a-f show bny injury or other traumatic event, it is Maria to a star in a feet of the intermediate of the contractions.		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street and Number	or Rural Route Number,	City or Town, State, Zip (	Code)
other trau		Lula Mae Tincher	<del></del>		Court, Baltim			
Baltimore, parmit. Pages 1a Department of Hee mportant: If item any injury or otha		20a. Method of Disposition 1 ★ Surial 2 □ Cremation 3 [	Removal from State		natory or other place)		c. Location - City or Tow	
Itim trant: rtant: njury		`4 □Donation 5 □Other (Special			1 Mem. Gard.No			
Ba Parm Pepa Impo Impo any ii		21. Signature of Funeral Service	nsee	22.	Name and Address of Facility Bruzdzin 407 Old Easter	ski Funeral	Home, P.A.	3 04 004
		23a. Part1. Enter the disease, or con	mplications that caused the	e death. Do not ente	er the mode of dying, such as c	ardiac or respiratory arres	ssex, Maryla	ING ZIZZI Approximate
Pnysician		Immediate Cause (Final	v one cause on each line.		_			nterval Between Onset and Death
/Medical		diseas or condition resulting in death)	a// JP // R	consequence of);	IXEUMO	NA		
Examiner		Sequentially list conditions	ATRIA	1 F11	PREUMO. SRILLATIO	X		
. ✓₽ ∺	Iner	and any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence or):				
and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a co	NJA				
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687 lifficate g phys as the			<u> </u> d.					
Box 6	N/U	IF FEMALE:						
atte atte		23b. Was decedent pregnant	23c. If yes, outcome of p				23d. Date of delivery	,
- p o o	icla	23b. Was decedent pregnant in the past 12 months?  1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	1 Live birth 2 □ 4 Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)		,	ay Year
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			Decedent's Name (First, Middle, L	ast)					2. Date of Dea	ith	004	3. Time of	Death
	Physici /Medi		Wanda C. Tomaszev	ski					Novembe	er 24	, 200	4 12:12	Ам
4	Examir	ner	4a. Facility Name (If not institution, gi	ive street and number	er)	4b. City, Town, o	or Location o	of Death			County of De		
			3516 Mase Lane 5. Social Security Number 6.	Sex 7.	Age (In yrs. last birthday	Bowie  If Under 1 Year	If Under 2	24 Hrs	O Data of Bird			eorges	
	Funeral Director	Н		1□M 2∏F	89 Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day 09 / 24 / 1	915	9. B	Birthplace (State o Country) diana	or Foreign
-	P.		Usual Residence of Decedent						05/24/1	713			
	show	2	10a. State 10b. County	•	10c. City, Town or L	ocation						10d. Inside Ci	•
	the N 28e-f	Director	Maryland Prince (	eorges	Bowie	10f. Zip Code				10a Citiza	on of What (		2 🗆 140
	3a or	Ö	3516 Mase Lane			Bowie				US.		Country	
	death	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S. 13.	Was Decedent of H	lispanic Orig	gin? (Spe	ecify Yes or No-		I. Race - An	merican Indian,	
36	or Ite	y Fu	1 Never Married 2 Married	1 Tes 2 [	-XN∘	1 ☐ Yes 2 ◯XNo		, Pueno	rican, etc.)		Black, Wh	nite, etc.	
9	hours tural;	ed by	3 ☐XWidowed 4 ☐ Divorced  15. Decedent's E	Year or Date							1	White	
15	within 72 hours after death with the Maryland ene. then "netural", or items 23a or 28e-1 show I'w Mudical Exami at must be notified at	piet	(Specify only highest g	rade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	of worki	ing	160. Kind	d of Busines	ss/industry	
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Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryla and Mental Hygiene. Is marked other than "natural", or flems 23a or 28e-1 show aumatic event, it w Modical Examinar must be notified at	Be	17. Father's Name (First, Middle, Las	t)					(First, Middle,	Maiden S	umame)		
3	should be and Mental s marked o umatic eve	2	Michael Moritz  19a. Informant's Name/Relationship	(Tuno Brint)	10h Maili	Add (O			bowski				
Ma	and 2 s eaith an n 27 is r er traur		Marlene Anderson/			ng Address <i>(Street</i> Mase Lar						, Zip Code)	
Ē,	- T 6 =		20a. Method of Disposition		20b. Place of Dispe				-			or Town, State	
Ë	Pages nent of I ant: If its ary or o		1   Burial 2 □ Cremation 3 [  4 □ Donation 5 □ Other (Spec		Memorial	mont Gardens		1/26	704 D	avid	sonvil	lle, Mar	v1and
Baltimore,	permit. Pages Department of I Important: If ite any injury or or once.		21. Signature of Funeral Service Lice	ensee	2	2. Name and Addre	ss of Facility	y Rob	ert E.	Evan	s Fune	eral Hom	e
ш	205 2		While Smit	4		000 Annar					yland	20715	
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each	line.					est,		Approximate Interval Bety Onset and D	ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- u.	sclerotic C	erebro Va	scula	r Di	sease			Years	, all
п	Examiner				as a consequence of):							Vacus	
		ner	E squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		es Mellitus as a consequence of):							Years	
	ocuted and transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Hy ert	ensive Card	iovascula	r Dis	ease				Years	
8760,	The law requires that the death certificate be executed te has been signed by the attending physician and agge 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or a	as a consequence of):								
687	icate physi s the t	dicai		d									
Вох	eath certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon						230	d. Date of de	elivery	
	death	icia	in the past 12 months? 1 ☐ Yes 2 <b>∑</b> No	4 ☐ Pregnant	at time of death 5	Ectopic pregnancy Other (specify)					Month		'ear
P.0	at the de by the stached	hys	9 Unknown	9Ll Unknown									
	ires tha signed I I be det	by	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause giv	en in Part I.					to the cause of de	
Ö	w requir been si should	eted								s 2 <b>X</b> )!		Probably 4 🔲 U	nknown
Vital Records,	The lay ate has page 2:	Completed							24a. Was a autops perform	y	24b. Were a prior to death?	utopsy findings a completion of ca	ivailable iuse of
ta		O	25. Was case referred to medical				26 Place	of Death	(Check only on		1 □ Ye	s 2 No	
Ž	S S	To B	examiner? 1 ☐ Yes 2 ▼No	Hospital: 1 🗆 Inpa	tient 2 ER/Outpatier	nt 3 DOA Oth			ne 5 Reside		Other (Sp.	ecify)	
			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, L	jury 28b. Time o Day Year) Injury	28c. Injur Wor			8d. Describe ho				
Division	tea fleat tor the	icati	2 Accident investigation	00 000 000			Yes 2 □ N		100				
-	or Attendate of after death I Director: /	Certification:	4 Homicide determined	building,	njury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, onice		2	City or Town	reet and N n, State)	iumber or H	Rural Route Numb	per,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a, Certifier 1 Certifying P	hysician: To the bes	st of my knowledge, death	occurred at the tin	ne, date and	place, a	nd due to the ca	iuse(s) an	d manner a	s stated.	
	in 24 in 24 in Fr	edical	(Check only 2 Medical Exa	miner: On the basis and manner	of examination and/or in	vestigation, in my o	pinion, death	occurre	d at the time, da	ate and pla	ace, and du	e to the cause(s)	
	To the within 2.  To the complete	Σ	29b. Signature and title of certifier		12 101	29c. License	e number		25	9d. Date s	igned (Mon	th, Day, Year)	,
	.6	,		rano!	(7)	D	20	10	8	11/	241	2007	
	/2		30. Name and address of person who	completed cause of	death (Item 23a) (Type,	Print) 300GA	LLA	NT	FUXL	NH	222	BOWLE	
	Sta	te	31. Date filed (Month, Day, Year)	32 Regis	trar's Signature						14	02671	5
	Registr		MDN 2 4 20	04 Som	trar's Signature	ule							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 20, 2004 11:05 PM Raymond Η. Trinque /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Nursing Center Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months 267-05-3120 September 5, 1920 Rhode Island Director Usual Residence of Decedent death with the Maryland worle 10a. State Rhode 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23e or 28e-f ehov The Madical Examiner must be notified at Providence North Smithfield 1 Yes 2 No Directo Island 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 67 Homecrest Avenue 02896 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after XYes 2□No WWII fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Specify: 3 X Widowed 4 □ Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 permit. Pages 1 and 2 should be fited within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than any injury or other treumatic event, the Mar Elementary/Secondary (0-12) College (1-4or 5+) Owner Car Dealership 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Trinque Anna Rousseau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shaun W. May/Nephew 1215 Main Street, Gaithersburg, Maryland 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State North Smithfield, cemetery, crematory or other place)
| St. John the
| Evangelist Cemetery November 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 27, 2004 Rhode Island Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 21. Signature of Funeral Service Dicensee americal Hollans M01305 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final Physician Lung Cancer Years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 Physician/Medical for use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 90 Renal Cancer, Atherosclerotic Cardiovascular Disease 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospitel or Attending Physicien: director Be 25. Was case referred to medical 26. Place of Death Check only one examiner's Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 70 1 ☐ Yes 2 X No 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending death. 1 TYes 2 TNo investigation 2 Accident Director: within 24 hours efter dea To the Funerel Directo 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifie 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check o Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier D28656 November 21, 2004 ress of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi, M.D. 15225 Shady Grove Road, #208, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

19 Sparks Maria.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 4 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Year **Physician** UMSTEAD EMILY 11: 45 P.M 2014 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Elder Care Nursing Home Baltimore Randallstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** 1□M 258F Deys Hours Months Director 218-18-6266 VA Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mentel Hygiene.

Int: If Item 27 is marked other than "natural; or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No **Funeral Director** MD NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1405 North Rosedale Street 21216 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0020 1 ☐ Yes X No Specify: Specify: À 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th grade na Custodian Balto School System 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Crawley Laura Crawley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Wallace S. Umstead-Husband 1405 North Rosedale Street, Balto, Md 21216

Oa. Method of Disposition | 20b. Place of Disposition (Name of Disposition | Date | 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Department of Important: if it any injury or o Buriel 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Garrison Forest Vet. 12/2/04 Owings Mills, Md 21. Signature of Funeral Service Licenses March F/H west 4300 Wabash Ave, Baltimore, Md 21215 ent1. Enter the J sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical RECTAL CARCINOMA Examiner Physician/Medical Examiner physician and the burial-trensit or Attending Physician: The lew requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vitai Records, P.O. 3 Probably 4 ₽ thknown 1 ☐ Yes 2 ☐ No CORONARY ARTERY 2 Be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy DEMENTIA completion of cause of death? 1 Yes 2LTNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Divising Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To this funeral 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 ( Natural 5 Pending investigation Injury after death.

Director: Afted in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined To the Hospital or Atterwithin 24 hours after der To the Funeral Director completally filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 29a. Certifier 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Do059107 m.D 11-23-2004 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 2600 LIBECTY M 814mTS BALTIMORE Uma WESTYDE MEDICAL GROW 31. Date filed (Month, Day, Year) 32. Registrer's Signature State NOV 2 9 2004 > Registrar

			For State Registrar		aryland /		artment of H rtificate of L			Reg. N	2007		37530
	Physici		1. Decedent's Name (First, Middle, La						2. Date of D Month	eath Da	,	4	3. Time of Death
	/Medic	al	Ann Therese We 4a. Facility Name (If not institution, given				4b. City, Town, or	Location of Deat	//	25	County of D	(	1150
	Examin	er	Franklin Square 1		tec		Boseda				Baltim		
	Funeral		5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. last b	irthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		irth			ce (State or Foreign
	Director			1□ M 2√F	87	Yrs.	Monato Bayo		Dec. 2	9, 1	916 N	lary	land
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	ocation					100	1. Inside City Limits
	Mary f sho	to	Maryland Baltin	nore			Baltimo	ore					1 ☐ Yes 2 ☑ No
	n the	Director	10e. Street and Number				10f. Zip Code			10g. Ci	itizen of What	Countr	y?
	th wit	alD	4235 Soth Avenu	ie			2:	1236			u.s	.A.	
	tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces? 1 ☐ Yes 2 💥	Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer	specify Yes or N to Rican, etc.)	0-	14. Race - A Black, W	mericar /hite, et	n Indian, c.
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔼 If Yes, Give Year or Dates:	No		1 ☐ Yes 2 💆 No	Specify:			Specify:	whit	0
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental hygiene. Importent: If item 27 is marked other than "netural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Exameter must be mailfied at once.		15. Decedent's E	ducation	16	a. Dece	dent's Usual Occupa	ation	1:	16b. k	Kind of Busine		
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Maryland	be fill bd oth	Be	17. Father's Name (First, Middle, Last John Drabuck					18. Mother's Nar		e, maidei Maci			
ž	hould id Mei mark matic	은	John Drabuck  19a. Informant's Name/Relationship		19	b. Maili	ng Address (Street a					e, Zip C	ode)
	and 2 salith an and 2 salith an		Frances Claire (				Heron Co					1871	
ē,	f Hea item othe		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of matory or other plac		Date		ocation - City	or Tow	n, State
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н			23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each li	ne.		1967		c or respiratory	arrest,		1	Approximate nterval Between Onset and Death
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П	Examiner			Due to D as	a consequence	9 01):							
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		/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						23d. Date of	deliven	,
Вох	atter for u	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1□Live birth 4□Pregnant a	2 Fetal dea		∃Ectopic pregnancy ∃ Other (s <i>pecify)</i>			- 5	Month		ay Year
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S, P	res tha signed be det	ру Р	Part II. Dther significant conditions	contributing to death t	ut not resulting	in the u	nderlying cause give	en in Part I.	1				cause of death?
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ec	law r	Completed							24a. Wa auto	s an opsy formed?	24b. Were prior death	to comp	y findings available pletion of cause of
E H									1 ☐ Yes	2 A N		/es 2	□ No
Z:	Physician: This certificated director, p	o Be	25. Was case referred to medical examiner?	Hospital:	ent 2□ER/0		other actions Other	20	ath (Check only Home 5 ☐ Res		6 00th at /6		
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Ö	Hospital or Attending 14 hours after death. Funerel Director: Afte tely filled in by the fune												
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medical		hysician: To the best miner: On the basis of and manner si	f examination								
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	120		30. Name and address of person who	completed cause of	death (Item 23a	) (Type,	Print)	D 11		1//	0.0		
			Dr. Java Singh 31. Date filed Month, Day, Year)	4000 Fra	n Klin rar's Signature	2940	are Drive	balt	more,	MU	2123	1	
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DI		\$	NOV 2 9 2	2004 /2	15/	- Far	a porte	2					

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			Registrar  1. Decedent's Name (First, Middle, La	ant l	Certificate of		Reg. N	£ UU4	3/531
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	Funeral Director		5. Social Security Number 6.5 225–26–2525	11. 1	rs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth Month, Day, Year, 2-24-23		hplace (State or Foreign untry) Va.
	pug **		Usual Residence of Decedent  10a. State 10b. County		City, Town or Location		2 21 20		
	the Marylan 28e-f show nytified at	Director	Mđ.	NA	Baltimore				10d. Inside City Limits 1 Y Yes 2 □ No
	with ti		10e. Street and Number 437 N. Robinson	Ctronst	10f. Zip Code	224	10g. Ci	itizen of What Cou	intry?
	ier death w items 23a	Funeral	11. Marital Status	12. Was Decedent Ever in	212 1 U.S.   13. Was Decedent of F	2.24 Hispanic Origin? (Specify pan, Mexican, Puerto Rical	Yes or No-	USA 14. Race - Amer	ncan Indian.
980	a o	by	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	Amed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	If Yes, specify Cub		n, etc.)	Black, White	
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	D D =		3rd Grade  17. Father's Name (First, Middle, Last		Environmenta				ity School
Maryland	Mental Mental arkad o	To Be	Graham	Wal	lker	18. Mother's Name (Fin			
Ma	d 2 s th ar 7 is treu	18	19a. Informant's Name/Relationship ( Jennifer Walker	Daughter	19b. Mailing Address (Street				
Je,	s 1 a f Hea item othe		20a. Method of Disposition	20b.	437 N. Robin  Place of Disposition (Name of cemetery, crematory or other pla	Date		ce Ma. ocation - City or T	
Ë	Pag nent ent: i		1 ☐Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif		Mt. Carmel Cem.	11-29-0	04 Dun	ndalk, Mo	3.
Baltimore,	permit. Departrimportrimports any injugance.		21. Signature of Funeral Service Licer	1see	22. Name and Addre	•	Baltimo	ore, Md.	21202
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Vital	Physicien: r this certifica ral director, I	Be	25. Was case referred to medical examiner?	Hospital:	Oth	26. Place of Death Ch			
of	Phy this	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 2 € 28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Wor	4   Nursing Home	5 Residence (		ý)
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Division of	s after des s after des al Diracto ed in by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, factory, office cify)	28f. L	ocation (Street and City or Town, State,	d Number or Rura )	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune.	Medicai (	29a. Certifier (Check only one)	ysician: To the best of my kr niner: On the basis of examin and manner stated.	nowledge, death occurred at the tin nation and/or investigation, in my o	ne, date and place, and d pinion, death occurred at	ue to the cause(s) the time, date and	and manner as si place, and due to	tated. the cause(s)
	To tl withi To tl	Ž	29b. Signature and title of certifier	11 20	29c. Licens	e number	29d. Dat	e signed (Month,	Day, Year)
•	0		For /	all MI	0 15	3368	Nov	ember 2	4, 200V
	1		30. Na and address of person who	completed cause of death (Ite	em 23a) (Type, Print)	Kin H.	11 30	V. W. wi	11717
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Emma Wyatt Co. Pt Knawn

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/Med Exam		4a. Facility Name (If not	institution, give	e street and number	<u>ull</u>	4b. City, Town, o	or Location of Death	NOV	30	County of I	Death	1090
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Funera Directo		213-32-3		□M 2MF	68	Yrs. Months Days	Hours Min.	8. Date of B	av Year	36	Country)	(Stare or For
land ow		Usual Residence of Dec 10a. State 10t	edent o. County		10c. City, Tow	m or Location •					10d.	Inside City Lir
Ba-f sh	ctor	MD		NA		Battimon	e					1 Ves 2□
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examinational to Indillieu at	Funeral Director	10e. Street and Number	rlau	M AIR	110	10f. Zip Code	21215		10g. Ci	itizen of Wha	t Country?	)
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permit. Pages 1 ar Department of Hea Important: If item at y injury or othe		21. Signature of Funera			Garr	22. Name and Addre	ss of Facility Vou	9/12 C	Gre	fres i	Yulls	1 ST
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nysician /Medica xaminer	by Physician/Medical Ex	23a. Part1. Enter the d shock, or heart and shock, or heart and limmediate Cause (Fina disease or condition resulting in death)  Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregint he past 12 moning 1 Yes 2 No 9 Unknown  Part II. Other significant	sease, or compure. List only of this?	b. Due to (or as  b. Due to (or as  c. Due to (or as  d. Live birth  4 Pregnant at  9 Unknown	a consequence a consequence a consequence of pregnancy 2 Fetal death time of death ut not resulting in	and enter the mode of dyinot enter the mode of dyinot enter the mode of dyinot):  of):  3   Ectopic pregnancy   S   Other (specify)	enty Rd. g, subthe cardiac in far en in Part I.	respiratory a	tobacco u	Month use contribute	delivery Day	Year
as been signed by the attending physician and Wedgica 2 should be detached for use as the burial-transit	by Physician/Medical Ex	23a. Part1. Enter the d shock, or heart and shock as a shock and shock as a shock and	sease, or compure. List only of this?	b. Due to (or as  b. Due to (or as  c. Due to (or as  d. Live birth  4 Pregnant at  9 Unknown	a consequence a consequence a consequence of pregnancy 2 Fetal death time of death ut not resulting in	and the underlying cause give	enty Rd. g, subthe cardiac in far en in Part I.	23e. Did	tobacco u Yes 2	Month use contribute  No 3	delivery Day	Year  Wearhings availings
te has been signed by the attending physician and must be provided for use as the burial-transit using the purial-transit	e Completed by Physician/Medical Ex	23a. Part1. Enter the d shock, or heart and shock or heart and shock or condition resulting in death)  Sequentially list condition and shock or condition resulting in death)  Sequentially list condition and shock or condi	sease, or compute. List only of the conditions o	b. Due to (or as  b. Due to (or as  c. Due to (or as  d. Live birth  4 Pregnant at  9 Unknown	a consequence a consequence a consequence of pregnancy 2 Fetal death time of death ut not resulting in	and the underlying cause give	enty Rd. g, subthes cardiac in Far	23e. Did 1 24a. Was auto perfr	tobacco u Yes 2 an psy 2 No	Month use contribute No 3  24b. Were prior death	delivery Day  e to the ca	Year  Wear  Year  Tolking availation of cause
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this certilicate has been signed by the attending physician and mubocial director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Ex	23a. Part1. Enter the d shock, or heart and shock, or heart and shock, or heart and shock, or heart and sease or condition resulting in death)  Sequentially list condition in death and shock and s	sease, or compure. List only of the conditions o	Due to (or as	a consequence a consequence of pregnancy 2 Fetal death time of death ut not resulting in	and enter the mode of dyinnot enter the mode of dyinnot enter the mode of dyinnot):    3   Ectopic pregnancy   5   Other (specify)	enty 60.  in far  en in Part I.  26. Place of Death  17.	23e. Did	tobacco t Yes 2 an psy promed? 2 2 No	Month use contribute No 3   24b. Were prior death 1  Y	delivery Day  e to the ca Probably autopsy f to comple ?	Year  Wear death
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this certificate has been signed by the attending physician and in ector, page 2 should be detached for use as the burial transit	Certification; To Be Completed by Physician/Medical Ex	23a. Part1. Enter the d shock, or heart of shock, o	gnant ths?  Pending investigation  Could not be determined	Due to (or as b. Due to (or as c. Due to (or as d. Due to	a consequence a consequence a consequence of pregnancy 2 Fetal death time of death ut not resulting in ont 2 FeVOu ry y Year) 28b. T In ury - At home, fai	and the underlying cause given the underlying ca	en in Part I.  26. Place of Death  27  Yes 2 \( \text{No} \)	23e. Did 1  24a. Was auto perfc 1 Yes a (Check only of City or Total Cit	tobacco to Yes 2: an psy ormed? 2: No one) idence how injure.	Month  use contribute  No 3   24b. Were prior death 1  Y  6  Other (S) y occurred	delivery Day  e to the ca Probably autopsy f to comple ('es 2 D	Year  Year  Luse of death  4 Donkno  indings availation of cause
4 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and majority filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical Ex	23a. Part1. Enter the d shock, or heart and shock and sh	gnant ths?  Pending investigation  Could not be determined  Certifying Physics  Certif	bilications that caused one cause one cause on each line.  Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as d	a consequence a consequence a consequence of pregnancy 2 Fetal death time of death ut not resulting in y Year) 28b. T In y Year) of my knowledge of examination and	tpatient 3 DOA Other injury Monday Mo	en in Part I.  26. Place of Death ar: 4 \( \text{ Nursing Hoi } \) yes 2 \( \text{ No} \)	23e. Did 1 24a. Was auto performe 5 Resi	tobacco t Yes 2 an psy ormed 2 2 No one) idence how injur	Month  use contribute  No 3 □  24b. Were prior death 1 □ Y  6 □ Other (S) y occurred	delivery Day  de to the ca Probably autopsy fito complete (**es 2**D**)  Rural Rot	Year  Year  Wase of death  A Donknow  Indings availation of cause
The death.  The de	To Be Completed by Physician/Medical Ex	23a. Part1. Enter the d shock, or heart I Immediate Cause (Fina disease or condition resulting in death)  Sequentially list condition resulting in death)  Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injurt that inthated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregin the past 12 monitory of Unknown  Part II. Other significant  25. Was case referred to examiner?  1 Yes 2 No 27. Manner of Death  1 Natural 5 2 28. Accident 3 Suicide 6 4 Homicide	gnant ths?  conditions	Due to (or as b. Due to (or as c. Due to (or as d. Due to	a consequence a consequence a consequence of pregnancy 2 Fetal death time of death ut not resulting in y Year) 28b. T In y Year) of my knowledge of examination and	and enter the mode of dyinnot enter the mode	en in Part I.  26. Place of Death en: 4 \( \text{ Nursing Hor} \) vat  Yes 2 \( \text{ No} \) ne, date and place, binion, death occurrence.	23e. Did 1 24a. Was auto performe 5 Resi	tobacco t Yes 2 san psy primed? 22 No one) idence how injur Street an wm, State cause(s) date and	Month  use contribute  No 3 □  24b. Were prior death 1 □ Y  6 □ Other (S) y occurred	delivery Day  de to the ca Probably autopsy fito complete (**es 2**D**)  Rural Rot as stated, due to the	Year  Year  Use of death  A Donkno  indings availation of cause

Registrar DHMH 17 Rev 1/2001 NOV2 9 : 2004

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			1 - For State Registrar	State of M	aryland / D	epartment of li	Health and M	lental Hygier	-	4 3752
			1. Decedent's Name (First, Middle	e, Last)				2. Date of Death	10. 2 0 0	3. Time of Death
	Physic		PAUL	V	WEIDM	AN		Month E	Year	1 8:30AM
	/Medi Examii		4a. Facility Name (If not institution				or Location of Death	100	4c. County of Dea	7}
			10040 Hac	ford Rd.	Gonesi	R	AITIMO	OF	,	
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birth			8. Date of Birth (Month, Day, Yea	9. Bir	hplace (State or Foreign
	Director		202-38-0162	1,0 M 2□F	78. Y	rs. Months Days	Hours Min.	2-25-6	26 Per	insulvania
	pu 🔪		Usual Residence of Decedent		10.00.5					1.091-00-19
	aryla shov	-	10a. State 10b. County		10c. City, Town	A				10d. Inside City Limits
	Ba-f	cto	MD		1	PALTIMO	re			1 A Yes 2 □ No
	or 2	Director	10e. Street and Number	<u></u>		10f. Zip Code		10g. (	Citizen of What Co	ountry?
	23a	a	121 10. An	in Ot.		21	231		USA	•
	r deg	Tue	11. Marital Status	12. Was Decedent Armed Forces?	?.	<ol> <li>Was Decedent of I If Yes, specify Cub</li> </ol>	Hispanic Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	or i	by Funeral	1 Never Married 2 Marr	If Yes, Give	No	1 ☐ Yes 2 No		,,	Specify: /	hite
8	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show he Medical Ever that hast be notified at	Q D	3 Widowed 4 Divorced	Year or Dates:					Spoonly. U	71()(.
21215-0036	"nat	Completed	15. Decedent (Specify only highes		- (	Decedent's Usual Occu Give kind of work done	during most of worki	ng 16b.	Kind of Business/	Industry
42	within	m d	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT use retire	9 <i>a)</i>		11/1	
2	filed with Hygiene sther tha		17. Father's Name (First, Middle,	l ast)		1 deal ea	19 Mathada Nama	(First, Middle, Maide	N/H.	
an	od o	Be	0, ,	3	d		TO. WOUTER'S TRAITE	(First, Middle, Maide	on Sumame)	
Ē	2 should be and Mental Is marked c	2	Charles C		dman	4-10	1 472	ec. U		20
Maryland			19a. Informant's Name/Relations	A : : 6:	190.1	Mailing Address (Street	and Number or Hura	I Route Number, City	or Town, State, 2	(ip Code)
	permit. Pages 1 and 1 Department of Health Important: If item 27 any injury or other tr. 2009.		20a. Method of Disposition	Dingle-Si	20h Place of I	Disposition (Name of	OL DI	ate 20c	IND	X1231.
፩	Pages nent of h ant: If ite ury or of		1 Burial 2 Cremation		cemetary	crematory or other pla	ice)	200.	Location - City or	Iown, State
≣	permit. Pag Department Important: I any injury o		`4 □Donation 5 □ Other (Sp			UNBEALCH	XP9-11-X	7-04 FO	rest -	till MO
Baltimore,	permit. Departn Importe any inju		21. Signature of Funeral Service I	Licensee	1	22. Name and Addre	ess of Facility BAL	TIMORET	212	341.
	Ø 0 = 0	1	Kimbella	U- XUNG	the	EVANSFU	NERACCH	APEL 882	OHAR FO	EPRP.
			23a. Part1. Enter the dise e, or shock, or heart fail re. List	omplications that caused on one cause on each li	the deeth. Do no	t enter the mode of dyi	ng, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Fine I disease or condition	1. 32	ogress	re De	Edme		10	Onset and Death
	/Medical		resulting in death)	Due to (or as	a c resequence of	):^_				
	Examiner		Sequentially list conditions	ke Ke	nal	Falls	9			
	ם ≅	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	20	à consequence of	110 1	t- · 6			
	ate be executed sysician and he buriat-transit	am	Cause (Disease or injury that initiated events	C.	want	Heart	- Janua	re		
Ö,	e exe ian a urial-		resulting in death) Last	0	a consequence of	Λ Λ.				
	ate b hysic he bu	Icai		d. Corre	A.M.A.	Jery D	beare			
õ	The law requires that the death certificat tte has been signed by the attending phy bage 2 should be detached for use as th	Physician/Med	IF FEMALE:	E:					- 1	77
P.O. Box 68	th ce tendi r use	2	23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	3 Ectopic pregnance			23d. Date of deli	very
	ed fo	slci	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at		5 ☐ Other (specify)	,		Month	Day Year
9	at the de by the a	Å.	9 Unknown							
	es tha igned be det	by	Part II. Other significant conditio	ns contributing to death b			ven in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ב	w requir been si should I		Mone	anthrich	e In	Imenony	Ur.	1 ☐ Yes 2	2□No 3∐Pro	bably 4 Unknown
ပ္ထ	e law ru has be je 2 sh	ompieted	Surge 1	Pulmonary	Hy	reten sie	~	24a. Was an	24b. Were aut	opsy findings available
ř	The la	E				)		autopsy performed?	death?	ompletion of cause of 2□ No
<u> </u>		e C	25. Was case referred to medical				26. Place of Death	(Check only one)	O I I Tes	2L1 N0
>	S S S	OB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outp	atient 3 DOA Oth		ne 5 Residence	6 DOther (Spec	6.1
0	ding Ph th. After thi funeral	n:T	27. Manner of Death	28a. Date of Injur	ry 28b. Tin	ne of 28c. Injur		8d. Describe how inju		797
ਠੁ	Attending r death. ector: After by the fune	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investig	g (Month, Day ation	<i>y Year)</i> Inju		Yes 2 □ No			
Division of Vital Records,	Atte	ific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned   28e. Place of Inju	ury - At home, farm	, street, factory, office	2	8f. Location (Street a	nd Number or Rui	al Route Number,
5	s afte	Certification:	4 Tromodo	building, etc	с. (Зреспу)			City or Town, Stat	е)	
	pspit hour uners y fills		29a. Certifier 1 Certifying	g Physician: To the best	of my knowledge, of	leath occurred at the tir	me, date and place, a	nd due to the cause(s	and manner as	stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	edical	(Check only 2 Medical E	examiner: On the basis of and manner sta	examination and/	or investigation, in my o	pinion, death occurre	d at the time, date an	d place, and due	to the cause(s)
	To t	Σ	29b. Signature and title of certifier			29c. Licens			ate signed (Month,	
			1200	Has	MD	1)	31464	(	1/26/	04
(	1		30. Name and address of person v	who completed cause of d	eath (Item 23a) (To	rpe, Print)			,	/
			SHOAIIZ A	1110	10 F21	W Evet	ma) St	frit ?	Of Ra	Ut. mp 2/2
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	5 4		James 3	- 0	7
	Registr	ar	NOV 2	9 2004 1/2	Endrand	& Som	the d			

			1 - State of Maryland / Departm	nent of Health and Me cate of Death	ental Hygien	11116 37536
	Physici /Medi		Decedent's Name (First, Middle, Last)  Ruby D. White		2. Date of Death Month Da	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number)  1435 Market St.	City, Town, or Location of Death Willards	40	County of Death Wicomico
	Funeral Director		5. Social Security Number  216-12-6199  Usual Residence of Decedent	nths Days Hours Min.	8. Date of Birth (Month, Day, Year, Sept. 23,	9. Birthplace (State or Foreign Country) 1921 MARYLA(VI)
	Maryland a-f show	tor	10a. State 10b. County 10c. City, Town or Location	ousville		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28a	al Direc		7. Zip Code 21030	10g. Ci	lizen of What Country?
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Madical Examinat must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married   1 ☐ Yes 2 🗗 No	pecedent of Hispanic Origin? (Spec specify Cuban, Mexican, Puerto Ri es 217/No Specify:	cify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: // // //
21215-0036	I within 72 ho liene. r than "natur It e Modical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's (Give kind or life. DO NO	Usual Occupation of work done during most of working of use retired)	g 16b. K	ind of Business/Industry
Maryland 2	should be filed with nd Mental Hygiene marked other thai umatic event, ILE	To Be C	17. Father's Name (First, Middle, Last) Albert Arvold Dugaa	18. Mother's Name (	(First, Middle, Maiden	Schlitzberger
	es 1 and 2 sho of Health and f item 27 Is m r other traum	1 187	Kacen Miernicki 3713 a  20a. Method of Disposition 20b. Place of Disposition	dress (Street and Number or Rural)	Perry Ha	or Town, State, Zip Code)  1 1 2 3 6  Docation - City or Town, State
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		4 Donation 5 Other (Specify)	4 Men Car 11-29	PO, TIMON	sium mo 21093
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	EFUL A LTE LUAT IN mode of dying, such as cardiac or	ICS FUNCELA respiratory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner	_	disease or condition resulting in death)  a. Due to (or as a consequence of):  Sequentially list conditions, b.	ncer		4 Montra
.0,	be executed iician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Lisance of injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):			
ox 68760	eath certificate be ex attending physician for use as the burial	/Medical	d			
O. B	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopi 4 ☐ Pregnant at time of death 5 ☐ Other	ic pregnancy r (specify)		23d. Date of delivery Month Day Year
Records, P.	w requires that been signed b should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.		ise contribute to the cause of death?
al Reco		Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
of Vital	his his	: To Be		26. Place of Death (6	5 Residence	
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Certification;	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, fac	Work? 1 ☐ Yes 2 ☐ No	d. Describe how injur	y occurred  d Number or Rural Route Number,
Δİ	spital or A nours after neral Direc filled in by		building, etc. (Specify)  29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occur	red at the time, date and place, and	City or Town, State	and manner as stated
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	one)  2 Medical Examiner: On the basis of examination and/or investigal and manner stated.	tion, in my opinion, death occurred 29c. License number	at the time, date and	place, and due to the cause(s) e signed (Month, Day, Year)
İ	8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	00056776	11)	27/04
	Sta	te	ROBERT L. CLINTON MD. 145 E ( 31. Date filed (Month, Day, Year)   32. Registrar's Signature	CARROLL ST.	SALISB	URY, MD 21801
DHI	Registr MH 17 Rev 1/20	Ē	NOV 2 9 2004 Renew &	Louisha		

11.1			1 - State Amend Item 23a&27 per	me G839 Lei	artment of He dicate of L	ealth and Me Death	ental Hygier Reg. I	2004	37535
	Physic	an	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	/Medi		MARK JOHN WI	77			NOVEMBER	19, 2004	2:55 P M
	Examir	ner	4a. Facility Name (If not institution, give street and number 32 KING CHARLES CT	ar)	4b. City, Town, or I			4c. County of Death BALTIMORE	· M
0	Funeral			Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		place (State or Foreign
0	Director		216-56-9526 MBM 20F)	414 Yrs.	Months Days	Hours Min.	Month, Day, Yes	PO MAG	ontry) VLAND
7	pue M		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Aaryla f shor	ō	Sinh of October 105		^ .				1 ☐ Yes 21 No
	r 28e-f show	Director	DAKILARO BALLIFORE  10e. Street and Number	16055	10f. Zip Code		10g.	Citizen of What Cour	ntry?
	ath with 23a or		32 King CHARLES ET.		2120	377		1) C A	
	ems a	Funeral	11. Marital Status 12. Was Decede Armed Force	nt Ever in U.S. 13.1	Was Decedent of His f Yes, specify Cuban	panic Origin? (Spec	cify Yes or No-	14. Race - Americ Black, White,	
36	or It	by Fu	Never Married 2 Married 1 Yes 25	No	1 □ Yes 2 No	Specify:	noun, oto.,	Specify:	eic.
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or Items 23a or 28e-f show ther the Modical Examinar must be notified at		3 Widowed 4 Divorced Year or Date:		dent's Usual Occupat	ion	16h	Kind of Business/In	1172
215	fwithin 72 ho jiene. r than "natu	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4c)	(Give	kind of work done du DO NOT use retired)	iring most of working	g 105.	King of business/in	dustry
21	filed within Hygiene. other than ant, the M	Com	127 RS-	SERV	10A 35:	ROR	A	PPLZ FOR	20
nd	be filed ntal Hygi ed other event, I	Be (	17. Father's Name (First, Middle, Last)	_		18. Mother's Name	(First, Middle, Maid	en Sumame)	
∠a	2 should be and Mental Is marked o	ပ	1. M.M. T. Wer	(کر		EDONA 1	- WEBI		
S	d2sh thand traun	18 3	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	g Address (Street ar	nd Number or Rural BALTL		y or Town, State, Zip	Code)
ē,	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	Da	ite 20c.	Location - City or To	own, State
Baltimore,	0 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta • 4 ☐ Donation 5 ☐ Other (Specify)	EVANTEVA	natory or other place,	1/07.3	\	3000 Will (	Janlan
alti	permit. Pag Department Important: I any injury o		21. Sun the of Fun - A Service Lice see	22	. Name and Address	of Facility_ Me	moriss	es man	a1234
ω_	89 = 88		Von Vieno	8	SOD HAR	FORD 120	DAD PAR	Wills Colar	ENLANO
			23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not ento line.	er the mode of dying,	such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical			Arrhythmia	associate	ed with Co	caine Us	9	Onset and Death
	Examiner		Due to (or a	as a consequence of):					
		Je.	Sequentially list conditions, if any, leading to immediate Due to (or a	as a consequence of):					
	xecuted and II-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
0,	be executed ician and burial-transit		resulting in death) Last Due to (or a	as a consequence of):					
68760,	rificate be executed og physician and as the burial-transit	edical	d						
_			IF FEMALE: 23c. If yes, outcom	ne of pregnancy				22d Date of deliver	
Вох	death cer attendir d for use	ciar	in the past 12 months?	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	Day Year
P.O.	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Completed by Physician/M	9 Unknown						
S, F	res tha iigned be de	by P	Part II. Dther significant conditions contributing to death	but not resulting in the ur	nderlying cause given	in Part I.	1	use contribute to th	ne cause of death?
ord	v requir been si should	ted					1 Tes	2 No 3 Prob	abiy 4 Unknown
Vital Records,	has b	nple					24a. Was an autopsy	24b. Were auto prior to cor	psy findings available mpletion of cause of
<u>=</u>	certificate rector, pag						performed?	death	
ξ		To Be	25. Was case referred to medical examiner?  **No Proposed	tient 2 ER/Outpatien	Other	26. Place of Death (		0.87.01t (0 (1	COLLE
Division of	를 다 를	n: T	27. Manner of Death 28a. Date of Ir		28c. Injury a Work?	4   Nursing Home	d. Describe how in	6 XOther (Specify ury occurred	) SCENE
ior	Attending Ir death. sctor: After	atio	2 Accident investigation	Day Year) Injury		es 2□No			
Ξ	or Atter de lirecte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of building,	njury - At home, farm, stre etc. (Specify)	et, factory, office	28	of Location (Street: City or Town, Sta	and Number or Rura ite)	l Route Number,
	pital o		One Continue AT Continue Physician Table						
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the besix and manner	of examination and/or inv	estigation, in my opin	, date and place, an nion, death occurred	d due to the cause at the time, date a	s) and manner as st nd place, and due to	ated. the cause(s)
_	To the within To the compl	Me	29b. Signature and title of certifier		29c. License r	number	29d. C	ate signed (Month, I	Day, Year)
			May vio Ma	ule MO	0 0	ME	NO	VEMBER 20	, 2004
			30. Name and address of person who completed cause of	death (Item 23a) (Type,	Print)	mn Charact	- D-1:		
			MARGAMAN D. KOR	Corio Sincatura	111 PG	am Street	t, Baltımı	ore, Mary	land 21201
	Sta Registi		31. Date filed (Month, Day Year) 2 9 200 4 32. Regi	ar's Signature	Secret ,				
		· 3		The same					

GAIL E WILLIAMS 04-7579

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo or

			1- For Unpend Item 23a, pt. II, 27 per me Registrar Co	G838 12-3-04 fas Welling	Reg. No. 37536
I	Physici		1. Decedent's Name (First, Middle, Last)  Out William	_ Me	ate of Death onth Day Year  N/FMRFR 25 2004 0.15 M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	VEMBER 25, 2004 9:15a M 4c. County of Death
5			UPPER CHESAPEAKE MEDICAL CENTER	BEL AIR	HARFORD
	Funeral Director		5. Social Security Number  6. Sex  1 M 2 F 7. Age (In yrs. last birthda)  Vrs.  Usual Residence of Decedent	If Under 1 Year   If Under 24 Hrs.   8. Da   Months   Days   Hours   Min.   Min.	tte of Birth   9. Birthplace (State or Foreign County)
	tryland show	_	10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	the Ma	ecto	MD HAKFOKO  10e, Street and Number	10f, Zip Code	1 □Yes 2页No
	3a or	by Funeral Director	44 Fort House Rd	21085	10g. Citizen of What Country?
	tema 2	uner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yolf Yes, specify Cuban, Mexican, Puerto Rican,	es or No- etc.) 14. Race - American Indian, Black, White, etc.
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or Itema 23a or 28a-1 show any figury or other traumatic event, Ite Midleal Examinan must be notified at once.	by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	Specify: (4) hite
215-0036	"natur	Completed	15. Decedent's Education (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
2121	filed within Hygiene. Ither than ent, ILE Man	omp	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	R1/A
	be filed stal Hygid of other event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	, Middle, Maiden Sumame)
Maryland	should be ind Mental rmarked o	2	John D. Inerres 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Civelyn	Schrueter
	1 and 2 sho Health and Iem 27 is my		Edward Williams 44	ing Address (Street and Number or Aural Route	e Number, City or Town, State, Zip Code)
Baltimore,	Pages 1 and of Heren of Heren It it item		20a. Method of Disposition  1 △ Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition cemetery, cre	osition (Name of practice)  Date	20c. Location - City or Town, State
Itim	permit. Pag Department Important: I any injury o		'4 □ Donation 5 □ Other (Specify) Parkwa	od Cemokry 11-29-	OY PARKVILLE MD
Ba	permit. Departr Imports any inj		Linberty U. Zawrotny E.	2. Name and Address of Facility BACT	MORE, MO DIDBY PEL, 8800 HARFORD RD
П			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic Ca	rdiovascular Disease	Onset and Death
В	Examiner				
	ted nsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury		
o,	an and rial-tra		that initiated events ' c. Due to (or as a consequence of):		
68760	rificate be executed ig physician and as the burial-transit	fedicai	d		
Вох 6	eath certifi attending   for use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	_	23d. Date of delivery
	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/	in the past 12 months?	□Ectopic pregnancy □ Other (specify)	Month Day Year
s, P.O	es that the de igned by the a be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I. 23	de. Did tobacco use contribute to the cause of death?
Records,	w require been sig should b		Degenerative Joint Disease		1 Yes 2 No 3 Probably 4 Unknown
Rec	The law cate has b page 2 sh	Completed		24	a. Was an autopsy autopsy findings available prior to completion of cause of death?
_		0	25. Was case referred to medical	26. Place of Death (Chec	Yes 2□No 1 1 Yes 2□No
of V	dir ys	To B	examiner? 1 🕱 Yes 2 □ No Hospital: 1 □ Inpatient 2₺ 🖼 ER/Outpatie	Other	☐ Residence 6 ☐ Other (Specify)
	ing Afte une	tion:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation	of 28c. Injury at 28d. De Work?  M 1 ☐ Yes 2 ☐ No	escribe how injury occurred
Division	If or Attending after death.  Director: After din by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined determined building, etc. (Specify)	reet, factory, office 28f. Loc	cation (Street and Number or Rural Route Number,
ō	oital or A urs after oral Directilled in by		Soluting, distriction, (Specify)		y or Town, State)
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medicai	29a. Certifier (Check only one)  1□ Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and due evestigation, in my opinion, death occurred at th	e to the cause(s) and manner as stated.  e time, date and place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
)			· lard Hallan ned	OCME	NOVENBER 16, 2004
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) PENN STREET, BALTIMORI	E, MARYLAND 21201
	Sta	te	31. Date filed (Month, Pay, Year) 2004 32. egistrar's Signatury	nesti)	

DONDRE D. WHITE 04-7526 UNK 04-381

> Physicia /Medic Examin

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Medical Executed to the Indiffed at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Division of Vital Records, P.O. Box 68760,

as been signed by the attending physician and 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

		Plea	ase Type or							-		_	gible.	
	For State Registrar		State	of Mar			artment of I tificate of			1ental Hy	-	201	04	37537
	Decedent's Nan	ne (First, Mida	lle, Last)			-	inoate or	Dout		2. Date of De				3. Time of Death
1		D. White					11 25 7			Month NOVEMB	ER		Year 2004	9:40p
r			on, give street and n IOLLINS FE		DO & D		4b. City, Town,					4c. Coun	ity of Deat	h
	5. Social Security I		6. Sex		ROAD In yrs. last birth	day)	If Under 1 Year	LIMORI If Under	L CT's	8. Date of Bi	rth		Q Diet	nplace (State or Foreig
	216-86-265	6	1 <b>⅓</b> M 2□F		36 Yr		Months Days	Hours	Min.	(Month, Di	ay, Ye	ar)	Mary]	untry)
ł	Usual Residence of 10a. State	10b. Count	4	1	Oc. City, Town	orlo	cation							10d. Inside City Limits
5	MD		NA		os. Oity, Town	01 20	Baltimo	æ						1 X Yes 2 No
2	10e. Street and Nu	ımber					10f. Zip Code				10g.	Citizen o	f What Co	untry?
1	1712 N. W	olfe Str	eet				212	213				US	SA	
5	11. Marital Status		12. Was Dec	cedent Ev	er in U.S.	13. \	Vas Decedent of I		igin? (Sp	ecify Yes or No	0-	14. Ra	ace - Amer	rican Indian,
3	1 Never Mar	ried 2 XMa		2 X No			Tes, specify Cub I□Yes 21 <b>X</b> INo	an, Mexica Specify		Hican, etc.)			ack, White	e, etc.
3	3 Widowed	4 Divorce	d Year or				2A0110	Эреспу.	· 			Spec	Blac	ek
2	(Spe	15. Deceder cify only highe	nt's Education ast grade completed	)	(0	Give	lent's Usual Occup kind of work done	during mos	st of work	ing	16b	. Kind of	Business/I	ndustry
completed by Lancial Billecia	Elementary/Sec 10	ondary (0-12)	College	(1-4or 5+)			00 NOT use retire <b>xenter</b>	a)				Home	Impro	vement
	17. Father's Name	(First, Middle,	, Last)			~	ACTION!	18. Moth	er's Name	e (First, Middle	, Maid	len Suma	ame)	
	Alfred John	nson							Ann	ette Micl	key			
	19a. Informant's N	lame/Relation	ship (Type, Print)		19b. N	Mailin	g Address (Street	and Numb	er or Rura	al Route Numb	er, Cit	y or Town	n, State, Z	ip Code)
	Aaron A.	White/ B	rother		50	34	Plymouth F	load Ba	1timo:	re, MD 2	£214			
	20a. Method of Dis		3 Removal from	Ctata	20b. Place of D	Dispo:	sition (Name of natory or other pla	ce)		Date	20c.	Location	- City or 1	Town, State
	` 4 ☐ Donation			State	King Memo	ori	al Park	1	126-(	04	I	Randa]	l1stow	n, MD
	21. Signature of F	uneral Service	Licensee		ń	22	. Name and Addre	ss of Facili	ty					
	1//		1.100	7	2							. Bal	timore	, MD 21217
	shock, or her Immediate Cause disease or conditi- resulting in death)	art failure. Lis (Final on	r complications that t only one cause on aDue to	wh	consequence of)	54	in Shut	,	wall		irrest,			Approximate Interval Between Onset and Death
	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or	mmediate edying r injury	b. Due to	(or as a c	consequence of)	):								
מו באמווווו	that initiated event resulting in death)	S		(or as a c	consequence of)	):								
1			d.											
	IF FEMALE: 23b. Was deceder in the past 12 1  Yes 2 9  Unknown	2 months?		birth 2 ( nant at tin	pregnancy ☐ Fetal death ne of death		Ectopic pregnanc Other (specify)	/					ate of deliv	rery Day Year
	Part II. Other signi	ificant conditi	ons contributing to	death but r	not resulting in th	he un	iderlying cause giv	en in Part I		23e. Did t	obacc	o use cor	ntribute to	the cause of death?
										10	Yes	2 No	3 ☐ Pro	bably 4 Unknown
										24a. Was	an	24h	Were aut	opsy findings available
										auto	psy rmed?	,	prior to co	ompletion of cause of
	25. Was case refe	rred to medica	ıt.					26 Place	of Dooth	1 Yes	2 🗆 N	No	1 X7Yes	2∐ No
	examiner? XXYes 2 □		Hospital:	Inpatient	2 ER/Outpa	atient	3□ DOA Ott	05		ne 5 ☐ Resi		6 70	har (Cana	(y) SCENE
-	27. Manner of Dea		28a. Date		28b. Tim	ne of	28c. Injur	y at		28d. Describe				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	1 ☐ Natural 2 ☐ Accident	5 🗌 Pendi invest	igation {//	1 0	(ear) Inju	6	M 1	Yes 2 🔀	No	Susjec	1	She	1	
	3 🗀 Suicide 4 Phomicide	6 Could determ	ninga 286. Plac	e of Injury ling, etc. (	- At home, farm Specify)		et, factory, office			28f. Location (S City or Tox	wn, Sta	and Num	400	al Route Number, Block of
	29a. Certifier (Check only one)	1 Certifyi 2 Wedical	ng Physician: To th Examiner: On the t and man	e best of r pasis of ex iner states	camination and/c	death or inv	occurred at the tir estigation, in my o	ne, date an pinion, dea	d place, a	and due to the	cause	(s) and in	anner as	stated
	29b. Signature and	title of certifie	or //	71			29c. Licens	e number			29d. E	ate signe	ed (Month,	Day, Year)
			U h	4			OCME			r	VOV	EMBE	R 23,	3004
	30. Name and add	ress of person	who completed cau	se of deat			Print) PENN STRE	er. F	የልፐ:ጥተ	MORE N	ΛΛ DV	VT ANT	7 21	201
	31. Date filed (Mor	nth, Day, Year	32.1	Registrar's	Signature		1		ال المالية	TALLEY I	W-1[/.	T TT-JT/J	1 41	ZUI

State Registrar

nov 2 P 2004

\$2. Registrar's Signature

111 PENN STREET, BALTIMORE, MARYLAND 21201

			For	State of Marylan					•
			1 - State Registrar		Ce	tificate of Dea	th	Reg. NE 004	37538
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last)  Dance le  4a. Facility Name (If not institution, give st	reet and number)	lar	Ooroug  4b. City, Town, or Locati	2. Date of D. Month	620 20, 20	04 11:45 1
	Examir	ner	Union Memorial			Baltimor		4c. County of De	am
	Funeral Director		211 01 3313	7. Age (In yrs.)	last birthday) Yrs.	If Under 1 Year If Un Months Days Hou	der 24 Hrs. 8. Date of Bi rs Min. 09 1	rth 9. B ay, Year) 4 64	irthplace (State or Foreign Country) MD
	yland now		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation			10d. Inside City Limits
	Ba-f st	ctor	MD NA	Bal	ltimo	ce			M∑Yes 2 No
	with th	Funeral Director	10e. Street and Number 3119 White Ave			10f. Zip Code 21214		10g. Citizen of What C	-
	ns 23	eral		2. Was Decedent Ever in U.	S. 13. 1		Origin? (Specify Yes or N	U.S.	A •
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. ad other than "natural", or Items 23a or 28a-f show event. The Medical Examination institution at	b	1 Never Married 2 Married 3 Nidowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes Give Year or Dates:		f Yes, specify Cuban, Mex I ☐ Yes 2 ANo Spec	Origin? (Specify Yes or Noican, Puerto Rican, etc.)  cify:		
15-(	in 72 h n "natu fedical	Completed	15. Decedent's Educa (Specify only highest grade	completed)	16a. Deced (Give life.	lent's Usual Occupation kind of work done during r DO NOT use retired)	nost of working	16b. Kind of Busines	s/Industry
S	should be filed withi and Mental Hygiene. Is marked other than aumatic event, Ite M	Com	12th grade	College (1-4or 5+) 2yrs		ousewife		Home	
Maryland	be filed htal Hygie od other event, II	Be	17. Father's Name (First, Middle, Last)				other's Name (First, Middle	, Maiden Sumame)	_
ryla	2 should be and Menta Is marked aumatic ev	ဥ	Dawad Yarboroug  19a. Informant's Name/Relationship (Type		10h Maille		rgie Blake		
Ma	s 1 and 2 should f Health and Men item 27 is marke other traumatic		Yaser Hagazy-Hus	·			mber or Rural Route Numb Baltimore		
Baltimore,	es 1 and 2 of Health litem 27 I		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ Re	20b. Pl		sition (Name of natory or other place)	Date	20c. Location - City o	
Ë	crament o		4 □Donation 5 □Other (Specify)	Ķir			11/22/04	Randalls	town, Md
Balt	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra 2005.		21. Signatur Funeral Se vio Licence	men	M2 4.3	Name and Address of Earth Wood BOO Wabash	est Ave, Balt:	imore, Md	
	Inysician:		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	septi	cem		as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a consequ	ience of):	sive cn	sis		34
	pe tis	iner	Sequentially list conditions, farry, beauting to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se siconsequ	ience of):				1 410
	ate be executed nysician and he burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ		ell disc	ease	<u>-</u>	Tugeans
760,	e be e /siciar e buria	calE	d.		·				
68	rtificat ng phy s as th		IF FEMALE:						
.O. Box	The law requires that the death certificaties has been signed by the attending phy age 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	<ul> <li>If yes, outcome of pregnar</li> <li>1 ☐ Live birth 2 ☐ Fetal</li> <li>4 ☐ Pregnant at time of de</li> <li>9 ☐ Unknown</li> </ul>	death 3 [	Ectopic pregnancy Other (specify)		23d. Date of de Month	blivery Day Year
D,	es that the igned by be detact	by Pt	Part II. Other significant conditions contr	ibuting to death but not resu	Iting in the ur	derlying cause given in Pa	art I. 23e. Did t	obacco use contribute t	o the cause of death?
ord	w require been sig should b						1	res 2 No 3 P	robably 4 Unknown
		Completed					24a. Was autor perfo 1 \( \text{Yes}		utopsy findings available completion of cause of
Vital	Physician; Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	spital:	-0.0	Othor	ace of Death Check only o		
	ding T. After fune	Η,	27. Mannyl of Death  1 Natural 5 Pending 2 Accident investigation		ER/Outpatient 28b. Time of Injury	3 DOA 28c. Injury at Work?  M 1 Yes 2		dence 6 □Other (Spenow injury occurred	ecify)
Division	al or Atteno safter deatl Poirector: d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	et, factory, office	28f. Location (S City or Tox	Street and Number or R vn, State)	ural Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical C	29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of my know r: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the time, date estigation, in my opinion, d	and place, and due to the leath occurred at the time,	cause(s) and manner a date and place, and due	s stated. e to the cause(s)
	To th To th comp	W	29b. Signature and title of certifier			29c. License numbe		29d. Date signed (Mont	
)	,		1/2	M		AU4176	5435S160191	Vovember	20, 2004
			Shannon L. Sh	pleted cause of death (Item 、そいひこん、M		Print) 101 East Ur	nversitu Parl	cwan Ralt	20, 2004 more MD 2013
:	Sta Registr	1.00	31. Date filed (Month, Day, Year)	32. Registrar's Signatu		draw.		130(11)	141416 / 102

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Stata Registrar		artment of Health and Natificate of Death		ene 1. No. 2004	37539
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last)  7 M. Z  4a. Faeility Name (If not institution, pive street a	inkhan nd nymber) Center	4b. City, Town, or Location of Death	2. Date of Death	Day: 6 Year) 4	
	Funeral Director		5. Social Security Number 6. Sex 10 M 2 Usual Residence of Decedent	7. Age (In yrs. last birthday)  ☐ F  7. Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Births Cours 32 MAK	place (State or Foreign http)
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, if a Madical Examine	Funeral Director	10a. State 10b. County  MD BALTIMO  10e. Street and Number  C20 Strafford D	R. Unital3	monium 101. Zip Code 21093		g. Citizen of What Cour	
5-0036	nours after de urai', or items l'Exeminer m	d by Fune	1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ÎYes 2 □ No es, Give ar or Dates:	Was Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:		14. Race - Americ Black, White, Specify:	otc.
2121	filed within 72 h Hygiene. other than "nate	Completed by	12	oleted) (Give	The state of the s	ring	Sb. Kind of Business/In	ership
Maryland	2 should be fi and Mental H Is marked ot aumatic ever	To Be	17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (Type, Pri	khan nt) 19b. Mailir	ng Address (Street and Number or Rui	e (First, Middle, Ma beth A al Route Number, C	M. Coug	Code)
3altimore, M	Pa Pa Pa		20a. Method of Disposition  1 Method of Disposition  2 Cremation 3 Remova  4 Donation 5 Other (Specify)	20b. Place of Dispo cemetery, crer	isition (Name of matory or other place)	Date 2-1-04	c. Location - City or To	own, State  M.D.
Balt	permit. Departrr Importa any inju		21. Signature of Funeral Service Licensee  23a. Part 1. Enter the disease, or complicationshock, or heart fallure. List only one cause	nu	2. Name and Address of Facility 8 800 17 a r TO r F BO er the mode of dying, such as cardiac	tuans 1+1more or respiratory arres	mo 2	Mony (es
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Se of each line.  ACUTE MYDCARDI  Due to (or as a consequence of):				Interval Between Onset and Death
8760,		dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	Oue to (or as a consequence of):  Oue to (or as a consequence of):				-
.O. Box 68	ie death certifi the attending I hed for use as	Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
<u>α</u>	w requires that it s been signed by should be detac	by	Part II. Other significant conditions contributions	ng to death but not resulting in the $u$	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the	
of Vital Records,		e Completed	25. Was case referred to medical		26 Place of Deal	24a. Was an autopsy performe 1 Yes 2	24b. Were auto prior to condeath?	psy findings available mpletion of cause of 2 X No
of Vi	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No Hospita	l: 1 Inpatient 2 ER/Outpatier . Date of Injury 28b. Time of	nt 3 DOA Other: 4 Nursing Ho		ce 6 Other (Specification)	у)
Division	r Attending er death. rector: Atter by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury  Place of Injury - At home, farm, str building, etc. (Specify)	Work? M 1 ☐ Yes 2 ☐ No		et and Number or Rura	l Route Number,
۵	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Cer	(Check only 2 Medical Examiner: O	To the best of my knowledge, deatt	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the caus	se(s) and manner as st and place, and due to	tated. the cause(s)
)	To the within complex	Me	29b. Signature and title of certifier	ul	29c. License number	29d	I. Date signed (Month,	Day, Year)
	Sta	ate	30. Name and address of person who complete FRANCIS KHOO, M. I 31. Date filed (Month, Day, Year)	many on the to the own a state of		MARYLAN	ND 21204	
DH	Regist	i e	NOV 2 9 2004	Bereve le	Sparks			
				ORIGINA	AL.			

				Please		nt in Black laryland / De					-	•	le.	
		•	For State Registrar		State of IV		-	ificate of				200	4 375	:1.0
			Decedent's Name (	First, Middle, Las	t)			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Doan	2. Da	ite of Death		3. Time o	of Death
	Physici /Medi		J	MAC	2161	612				1	onth $2$		Year 7,2	25p.M
	Examir		4a. Fecility Name (If n	_		)	4	4b. City, Town, o				4c. County of		
			NORTHWEST  5. Social Security Num	abor 6 S	9Y 7 A	ge (In yrs. last birthe	tav)	RANDAL If Under 1 Year		er 24 Hrs   o De	to of Dirth	BALTIM	10RE 9. Birthplace (State	or Foreign
,	Funeral		219-42-6		_M 2M F	59 Yr		Months Days	Hours	Min. FEE	onth, Day, Yes	1945	Country) M	_
16.0	D		Usual Residence of D	ecedent										
	faryia f shov	5		Ob. County  BALTIMO	חחב	RANDAI							10d. Inside (	s 2 No
	the h	Director	MD 10e. Street and Numb		INE	KANDAI	LS	10f. Zip Code			10g.	Citizen of Wh		
	th with		8827 SIGR	ID ROAD				21133	3			U.S	S.A.	
	tems st.ms	Funeral	11. Marital Status	v	12. Was Deceden Armed Force	t Ever in U.S.	13. Wa If Y	as Decedent of H	lispanic ( an, Mexic	Origin? (Specify Y	es or No- etc.)		- American Indian, White, etc.	
36	rs afte	by Fu	1 Never Married 3 Widowed 4		1 ☐ Yes 2 € If Yes, Give Year or Dates		1 🗆	Yes 2 No	Specia	fy:		Specify:	WHITE	
00-	d within 72 hours after death with the Maryland Jene r than "natural", or Items 23a or 28a-f show I're Medical Enatiliset Institled at		1:	5. Decedent's Ed	lucation	16a. D	eceder	nt's Usual Occup	pation		16b.	. Kind of Busi	iness/Industry	
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121	ified with Hygiene. other than		17. Father's Name (Fi	ret Middle   ast)	2	CLI	ERK		18 Mol	ther's Name (First		EWSPAP		
and	be de la la la la la la la la la la la la la	To Be	LEON	ist, Middle, Cast)	.1	HE	СНТ		BE1		, middie, maid	en sumame,	WAHMAN	
Maryland 21215-0036	2 should be and Mental is marked aumatic ev	F	19a. Informant's Nam	e/Relationship (	Type, Print)			Address (Street		nber or Rural Rout	e Number, Cit	y or Town, Si		
Σ,	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		CARL ZIGL	ER / HUS	SBAND		_		RD.	RANDALLS				
Baltimore,	m O			Cremation 3	Removal from Stat		crema	tory or other plac		Date 11/2/	0.5		ity or Town, State	ΝD
Him		-	*4 □ Donation 5		·	LIBERTY							LSTOWN, N S., INC.	טוי
Ba	permit. Departr Imports any inju		Sun	AM.	attle								E, MD 21	208
			23a. Part1. Enter the shock, or heart f	disease, or com failure. List only	olications that cause one cause on each	ed the death. Do no line.	enter	the mode of dyir	ng, such a	as cardiac or resp	iratory arrest,		Approxima Interval Be	tween
	Physician		Immediate Cause (Findisease or condition	nal	a.	SE	US	IS					Onset and	Death
	/Medical Examiner		resulting in death)		Due to (or a	s a conse uence of		NONIA					Dui	2
		ē	Sequentially list cond if any, leading to imm	ediate <b>II</b>	b. Due to (or a	s a consequence of)		* (O) VIA					7	J
	cuted nd ransit	Examine	Cause (Disease or inj that initiated events	ury	c									
60,	be executed sician and burial-transit		resulting in death) Las	st	Due to (or a	s a consequence of)	:							
9 89	<b>u</b>	edicai			. d									
Box 6	eath certifica e attending phy for use as tha	n/Me	IF FEMALE: 23b. Was decedent p	regnant	23c. If yes, outcom							23d. Date	of delivery	
	The law requires that the death certifica tie has been signed by the attending phoage 2 should be detached for use as the	Physician/M	in the past 12 mills 1  Yes 2 1			2 Fetal death at time of death		ctopic pregnancy Other <i>(specify)</i>	y 			Month	h Day	Year
P.0	that the died by the detached	Phy	9 Unknown Part II. Other significa	ant conditions o		but not reculting in t	ao und	orbing cause au	on in Do	41 2	3e. Did tobaco	o uso contrib	ute to the cause of	doath?
ds,	signe d be c	d by	Corel	DVCSCL	var 1	Polaret		(and	WW .	ywalt			Probably 4	
of Vital Record	w requir	Completed	Corun	allia	teix de	Relie .		The same of the sa		2	a. Was an	24b. We	ere autopsy findings	available
Re	The lav	ошь			0					11	autopsy performed ☐ Yes 2/30	prie	or to completion of ath? ☐ Yes 2 ☐ No	cause of
ital	ician: Th certificete rector, pag	Bec	25. Was case referred examiner?	d to medical					26. Pla	ice of Death (Che				
of V	8 0 7	2	1 ☐ Yes 2 ☐ KNo	0	Hospital: 1 Impa			3□ DOA Oth	401	Nursing Home 5				
	ding After fune	tion	27. Manner of Death  1 Natural  2 Accident	5 Pending investigation	28a. Date of In (Month, E	ay Year) 28b. Tin Inju		28c. Injur Wor M 1	rk? Yes 2[		escribe how in	ilary occurred	1	
Division	of or Attending efter death.  Director: After in by the fune	Certification;	3 Suicide	6 Could not be determined		njury - At home, farm atc. (Specify)	, stree	t, factory, office			cation (Street ty or Town, St		or Aural Aoute Nui	mber,
Ö	Ital or rs efte ral Dir led in	Cert	4 _ Homode		building, (	яс. (Эреспу)					ly or rown, sa	a10)		
	Hospital	edical	(Check only 2	☐*Certifying Ph ☐ Medical Exan	niner: On the basis	t of my knowledge, of examination and/	or inves	stigation, in my d	pinion, d	eath occurred at t	he time, date a	and place, an	d due to the cause(	
	To the Hospital or Attent within 24 hours efter deatl To the Funeral Director: completely filled in by the	Med	one) 29b. Signature and tit	le of certifier	and manner s	nated.		29c. Licens	e numbe	r	29d. (	Date signed (	Month, Day, Year)	
}	⊢ s ⊢ ŏ		D (1)	Paro	evou	MD		D5	428	38	1	loven	NS9 2181	2004
	n		30. Name and addres			death (Item 23a) (Ty	pe, Pri	int) M	citt	Just	Hoxant	apio.	Month, Day, Year) Why Zi &t	-
			31. Date filed (Month,	Pay Year)	1	trac Signature	1-0	) (	VIVU	1 4	1 10/1000		7	
	St: Regist			12 9 200	A January	March &	J	Sporks	/					

State of Maryland / Department of Health and Mental Hygiepen () 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 35.7M OVENBER 6, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death LOPKINS HOSPI +AL Alt, MORE 1.74 Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1₩ 2□F Hours none Director 44 Yrs Rep of Georgia 1960 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location item 27 ia marked other than "natural", or items 23e or 28e-f show other traumatic event. If a Madical Example I was be inclided at 10d. Inside City Limits MD Baltimore Director Owings MI11s 1√2 Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 26 Richmar Road Apt. L Funerai 21117 Rep. of Georgia 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, In a Marical Examinar 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ 3 Widowed 4 Divorced Specify White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cleaner Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ipolite Anjaparidze Babilina (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gocha Peranidze (Friend) 7 Woodthorne Court Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kutorisi, Municipal Cemetery 11/13/04 Rep. of Georgia 22. Name and Address of Facility Bergen Funeral Service 21. Signalus of Funeral Service Licenses 330 Boulevard Hasbrouck Heights, NJ 07604 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im rediate Cause (Final direase in condition resulting in death) Priysician SUBARACHNOID /Medical Examiner Rupture MEURUSM S - uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial-1 attending physician Box 68760, Physician/Medicai the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) Division of Vital Records, P.O. the 9☐ Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2 No 2 No 1 Yes 1 Yes funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No P Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ate of Injury (Month, Day Year) 27. Manner of Death Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicíde 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide filled 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and title of certifiers 29c. License number 29d. Date signed (Month, Day, Year) RES -000 NOVEMBER 6, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WOLFE SHREET, BALL, MORE, MD 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 0 2004 Registrar

		1 - For State Registrar		epartment of Health and Certificate of Death	Mental Hygier	Z U U U 4 3 15 4 2
Physic		1. Decedent's Name (First, Middle, Las  INEZ ELIZABET			2. Date of Death	3. Time of Death
/Med Exami		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deal Ft. Washington,	th 4	tc. County of Death  Pr Geo Co
Funera Director		5. Social Security Number 6. Security Number 11 Sec	7. Age (In yrs. last birtho	Months Days Hours Min		9. Birthplace (State or Foreign Country)  North Carolina
he Maryland :8a-f show	Director	10a. State 10b. County  MD Pr Geo Co	10c. City, Town o	hington		10d. Inside City Limits 1 ☐ Yes <b>X</b> XNo
th with the 23a or 2	ai Dire	12021 Livingston	Road	10f. Zip Code 20744		Citizen of What Country?
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. T is marked other than "neturet", or items 23a or 28a-f show treumatic event, the Madical Examitter roust be netified at	d by Funeral	11. Marital Status  1 ☆ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2  No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036 d within 72 hours af giene. er than "neturel", or the Medical Exerci-	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of wo fe. DO NOT use retired)  edical Clerk	rking	Kind of Business/Industry
Maryland 212' d 2 should be filed withir th and Mental Hygiene. it is marked other than treumatic event, the M	To Be Co	17. Father's Name (First, Middle, Last)  Thomas Lee Alex		18. Mother's Nat	me (First, Middle, Maide Connor	alth Care
Baltimore, Mary permit. Pages 1 and 2 sho Department of Health and Importent: If them 27 is ma any injury or other treum ang injury or other treum.		Velma Burkley - F)  20a. Method of Disposition  20a. Method of Disposition  4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens	Removal from State  20b. Place of Dicemetery, York M	isposition (Name of crematory or other place)  emorial Park  22. Name and Address of Facility  Be	-17-2004 Cha	Ashington, Md 20744 Location - City or Town, State rlotte, NC 28217 Home, PA
cate be executed xB physician and murial-transit about the burial-transit about the burial-trans	dicai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death)  Securating list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ilications that caused the death. Do not ne cause in each line.  a.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to as a consequence of):	enter the mode trying, such as cardiac the mode trying, such as cardiac the mode trying as cardiac the mode trying as cardiac the mode trying, such as cardiac the mode trying, such as cardiac the mode trying, such as cardiac the mode trying, such as cardiac the mode trying, such as cardiac the mode trying, such as cardiac the mode trying, such as cardiac the mode trying, such as cardiac the mode trying, such as cardiac the mode trying, such as cardiac the mode trying, such as cardiac the mode trying, such as cardiac the mode trying, such as cardiac the mode trying, such as cardiac the mode trying trying the mode trying trying the mode trying tr	c or respiratory arrest,	Approximate Interval Between OTEst and Death
the death certifi the attending of the attending of	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
w requires that in the second by should be detailed by	by	Part II. Other significant conditions co	ntributing to death but not resulting in th	e underlying cause given in Part I.		use contribute to the cause of death?
VII.al INC. iicien: The law r certilicate has be rector, page 2 sh	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
This ral di	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Ma0ner of Death  1 Natural 5 Pending 2 Accident investigation	All Inpatient 2 ER/Outpate 2 ER/Outpate 28a. Date of Injury (Month, Day Year) 28b. Time Injure	tient 3 DOA Other: 4 Nursing H	th (Check only one) ome 5 ☐ Residence 28d. Describe how inju	
tiel or Attending rs after death.  Tal Director: After led in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
the Hospitel hin 24 hours a the Funeral I	edical	29a. Certifier 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowledge, do ner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	, and due to the cause(s rred at the time, date an	s) and manner as stated. d place, and due to the cause(s)
To the 1 Within 2 To the 1	Σ	29b. Signature and title of certifier	12.	29c. License number	29d. Da	ate signed (Month, Day, Year)
/ (5)		30. Name and address of person who co	WH 7700, OLD	BRANCH AND CL	-iNTON,	MD 20735
Sta Regist	_	31. Date filed (Month, Day, Year)  NOV 1 2 2004	2. Registrar's Signature	and I		

			For State Registrar	State of I	Maryland /		artment rtificate					iene a. N2 0 0 4	3751.3
			1. Decedent's Name (First, Middle	e, Last)							2. Date of Death	1 _	3. Time of Death
_	Physic /Medi		Patty	Rebecca	Вес	kei	<u>-</u>			N	Month Ovember	Day Year 12. 2004	
	Exami		4a. Fecility Name (If not institution	a, give street and number	er)		4b. City, T	Town, or L	ocation o	of Death		4c. County of De	eath
	•		Clearview Number 5. Social Security Number					erst		0.411		Washi	
	Funeral Director		239-01-9298	6. Sex 7	Age (In yrs. last bi 86	vrthday) Yrs.	If Under 1 Months	Days	Hours	Min.	Month, Day,	Washi 9. B 15,1917	Sinthplace (State or Foreign Country) North Carolin
		1	Usuel Residence of Decedent							141	ovember	15,1917	North Carolin
	nylan how		10a. State 10b. County		10c. City, Tov	vn or Lo	cation						10d. Inside City Limits
	e Ma	cto	Maryland Wash	nington	Hag	gers	town						1)X Yes 2 □ No
	or 24	Die	10e. Street and Number				10f. Zip (	Code			10	g. Citizen of What (	Country?
	ath v	-E	1302 Cedarwood			-		1740				U.S.A.	
	ltem Item	in in	11. Marital Status	12. Was Decede Armed Force	s?	13.	Was Decede f Yes, specif	ent of Hisp fy Cuban,	panic Orig , Mexican	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
336	urs af	by Funeral Director	1 Never Married 2√ Marr 3 Widowed 4 Divorced	ied 1 ☐ Yes 2 ☐ If Yes, Give Year or Date:	•		1 ☐ Yes 2	X) No	Specify:			Specify:	White
21215-0036	2 should be tiled within 72 hours after death with the Maryland and Menial Hygiane. Is marked other than "natural", or Itema 23a or 28e-f show aumatic event, the Medical Examinar must be notified at	Completed	15. Deceden	's Education		. Deced	lent's Usual	Occupati	ion		1	6b. Kind of Busines	
215	thin 7	Pe	(Specify only highes Elementary/Secondary (0-12)	College (1-4c	or 5+)	life. L	kind of work DO NOT use	done du retired)	ring most	of working			
	ed wi	် ပ	12			Но	memak					Own Home	
ng L	be fill ntal H od oth	Be	17. Father's Name (First, Middle, Thomas	Last) Jackson	Harri			1				aiden Sumame)	
3	d Mer narke	٤						-		nristi			eard
Maryland	d 2 sl th and the r		19a. Informant's Name/Relations  James R. Becker		198							City or Town, State,	
	1 and Health tem 27 other to		20a. Method of Disposition	HUSDAHU	20b. Place o	of Dispo	sition <i>(Name</i>	of of	4	rive,	hagers	stown, Md Dc. Location - City o	. 21740
<u>o</u> E	ages ant of nt: If i		1 ☐ Burial 2 【☐ Cremation 1 ☐ Donation 5 ☐ Other (S)		Hagerst		natory or oth	, ,	1	12 (			
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28e-f show any Injury or other traumatic svent, tra Madical Examinar must be notified at ance.		21. Signature of Funeral Service	Licensee	nagerst					?-13-C	)4   F	lagerstow	n, Maryland
ä	Depe Impo		A. hoel	Brady		A	ndrew O Fast	K. (	Coffn	nan Fu um Str	neral H	lome, Inc agerstown	. Md. 21740
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	ed the death. Do	not ente	er the mode	of dying,	such as c	cardiac or re	espiratory arres	it,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition		120m								Onset and Death
1	/Medical Examiner		resulting in death)		is a consequence								PS ::02-03
	Zammer	-	Sequentially list conditions,	b	is a consequence	-0-							
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequence	or):							
Ć,	execun n and ial-tra	Exar	that initiated events resulting in death) Last	c Due to (or a	is a consequence	of):							
8760,	icate be executed physician and s the burial-transit	dicai		d									
89	ntifica ng ph	Jedi	IC COMMIC.										
Вох	eath certifi attending   for use as	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	e of pregnancy 2 Fetal death	3□	Ectopic preg	mancv				23d. Date of de	elivery
0	at the dec by the al	Physician/Me	1 Yes 2 No	4☐ Pregnant 9☐ Unknown	at time of death		Other (spec					Month	Day Year
P.O.	that the ed by detac		Part II. Other significant conditio	ns contributing to death	but not resulting in	the un	derlying cau	rea given	in Part I		23a Did tobar	noo uso contribute t	o the cause of death?
of Vital Records,	slgn d be	d by	<b>-</b>		Dat Hot roodking is	7 (110 1211	derlying cau	so given	mran.				robably 4 Authown
Ö	w requ	Completed								—			
Re	The lav									_	24a. Was an autopsy performe	d? death?	utopsy findings available completion of cause of
ta		0	25. Was case referred to medical					2	6 Place	of Death (C	1 Yes 2 4	No 1 ☐ Yes	s 2□ No
<u> </u>	/sic	To B	examiner?	Hospital: 1 ☐ Inpat	ient 2 ☐ ER/Ou	tpatient	3□ DOA					e 6 □Other (Spe	acifu)
0			27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of In		Time of	28c	Injury at			Describe how		isity)
Si	ttending I death. tor: After the funer	catio	2 ☐ Accident investig	ation			М		s 2 □ No	0			
Division	Iran Iran	Certification;	3 Suicide 6 Could n 4 Homicide determine	ned 286. Place of in	njury - At home, fa etc. <i>(Specify)</i>	rm, stre	et, factory, o	office		28f.	Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number.
	pitel ours e eral [		29a. Certifier 1 Certifying	Observation T. W. I									
	To the Hospitel or At within 24 hours efter of To the Funeral Dirac completely filled in by	edicai	(Check only 2 Medical E	Physicien: To the bes examiner: On the basis and manner s	of examination and	dor inve	occurred at a state of the stat	tne time, my opini	date and ion, death	place, and occurred a	due to the caus at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
	To the rough of th	Re	29b. Signature and title of certifier				29c. L	icense n	umber		29d.	Date signed (Mont	h, Day, Year)
<b>a</b>			- t2x	tt mo			D	(80	19		~	av /2,2	2004
1	2H-5	1	30. Name and address of person w				rint)						
2	),		VASANT DATE	4, MD 3.	romic	C 5	7 1	TAG	ER.	5706	JAV, N	0 217	uo
33	Star Registra	te ar	31. Date filed (Month) pay (rear)	2004 32. Regist	rar's Signature	A	. W.						
		-11		1	100	10/0	mental.						

State of Maryland / Department of Health and Mental Hygien 004 37544 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MINOV 6,2004 Year **Physician** Lorenzo Barnes 1A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Thomas More Nursing & Rehab Center Hyattsville Prince George's If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day Year) Sept 10, 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 238-12-9669 1 XM 2□ F North Carolina 88 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "netural", or items 23e or 28a-f show any injury or other traumatic event, the Marical Exercities in once.  $\mathbf{M}$ N/A 1 XYes 2 ☐ No Washington Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 22782 438 Riggs Rd. NE. U.S.A. Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1942-1946 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk U.S. Covernment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Barnes Ada Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 438 Rigges Rd. NE. Washington, DC 22782 Dora Barnes - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 □ Cremation 3 □ Removal from State 11/12/04 First Bapt Church Cem. ` 4 ☐ Donation 5 ☐ Other (Specify) Severn NC. 21. Signature of Fun ral Service Licens 22. Name and Address of Facility Fasion's Funeral Home 301 Park St. Seaboard,NC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiolespitatou **Physician** /Medical Due to (or as a consequence of): Examiner pester Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (b) as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by eumona 1 Yes 2 No 3 Probably 4 Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has blirector, page 2 s autopsy performed? (es 2X) No 1 ☐ Yes or Attending Physician: ours after death,

eral Director: After this certific
filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred | Certification; Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0060999 W(1) asmula Mua 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PASPULA106 Irving St. South Tower Suite 415 31. Date filed (Month, Day, Year) State NOV 1 2 2004

Registrar

		Ь	1- State of Maryland / Dep Registrar Ce	partment of Health and Mental Hygi ertificate of Death	2004 37545
	Physici		1. Decedent's Name (First, Middle, Last) Ella Blakeney	2. Date of Death Month Nov. 8	Day Year 3. Time of Death 3th. 2004 4:20p
	/Medio Examir		4a. Facility Name (If not institution, give street and number)  Andrew Airforce Base Hospital	4b. City, Town, or Location of Death  Camp Spring	4c. County of Death Prince Georges
Ī	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 🛱 91 Yrs.		Year) 9. Birthplace (State or Foreign
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State	ocation	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	3a or 28a	Il Director	10e. Street and Number 6439 Hillmar Dr. Apt#304	10f. Zip Code 20747	g. Citizen of What Country?
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "netural", or iteme 23a or 28a-f ehow aumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1  Never Married 2 Married  3  Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☒ No Specify:	14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036	d within 72 ho piene. ir then "netur Ina Medical	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)  Domestic	6b. Kind of Business/Industry  Home
yland ;	should be filed and Mental Hyg marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last)  Julius Lowery	18. Mother's Name (First, Middle, M Anna Burch	aiden Sumame)
, Mar	and 2 sho eelth and m 27 ie m		Louise Hunter / Daughter 6439	ing Address (Street and Number or Rural Route Number, Hillmar Dr. Apt#304 Forst	ville,MD. 20747
Baltimore,	permit. Pages 1 and 2 should be Depertment of Heelth and Menta Important: if item 27 is marked ent injury or other traumatic e 200.		'4 Donation 5 Other (Specify) Maryland	National 11/15/2004	Oc. Location - City or Town, State  Laurel, MD.
Bal	Depermit Depermit Impor		Gran Gruck gull 3	2. Name and Address of Facility Rhines Fun 015 12th. St.,N.E. Washin	
8760,	ficate be executed  X  Thysicien end  Examiner and the purial-transit  Strip burial-transit	il Examiner	23a, Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	2 (TIL COLID VILLE)	Interval Between
P.O. Box 687	The law requires that the deeth certificate ite has been signed by the attending physioage 2 should be detached for use as the I	Physician/Medical		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
rds, P	w requires that s been signed b should be deta	Ď	Part II. Other significant conditions contributing to death but not resulting in the u	14 40 (	cco use contribute to the cause of death?
II Reco	The law resete hes bee page 2 sho	Completed		24a. Was an autopsy performe 1 ☐ Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  No 1 \sum Yes 2 \sum No
f Vita	Physician: rthis certifice ral director, p	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatier	26. Place of Death (Check only one)  nt 3 DOA Other: 4 Nursing Home 5 Residence	
Division of Vital Records,	To the Hospital or Attending Physicien: The law within 24 burus after deeth. To the Funeral Director: Attenthis certificate hes completely filled in by the funeral director, page 2	Certification;	27. Manner of Death 1 Natural 2 National 3 Suicide 6 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time o	if 28c. Injury at Work?  M 1 □ Yes 2 □ No  reet, factory, office 28f. Location (Stre	et and Number or Rural Route Number,
Ö	To the Hospital or Attending within 24 hours after deeth. To the Funeral Director: After completely filled in by the fune	edical Certi	29a. Certifier (Check only)  10 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in	b occurred at the time, date and place, and due to the cau	se(s) and manner as stated
)	To the Hospital within 24 hours a To the Funeral I completely filled	Medi	29b. Signature and title of certifier	29c. License number 29d	I. Date signed (Month, Day, Year)
K	25		30. Name and address of person who completed cause of death (Item 23a) (Type, MARC SHEPARD 4700 BERW)	Print) YN HOUSE Rd 105A C	Ollege PARK, MD
	Sta Registra		31. Date filed (Month, Day, Year) NOV 1 2 2004	L.	

1 - For State Registrar Certificate of Death

Reg. No.		
Date of Death		3. Time of Death
Month Day	2004	/ . 2/ m h

**Physician** /Medical Examiner

**Funeral** Director

filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or items 23a or 28a-f show 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at should be f permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 Is m any injury or othar traum odce.

Baltimore, Maryland 21215-0036

Director

Funera

**Physician** /Medical Examiner

Examiner

Certification:

Patel Layanti

NOV 1.2 2004

31. Date filed (Month, Day, Year)

nding physician and use as the burial-transi been signed by the sahould be detached After thi within 24 hours after death To the Funeral Director: filled in by the

The law requires that the death certificate be executed

or Attanding Physician:

Division of Vital Records, P.O. Box 68760.

1. Decedent's Name (First, Middle, Last) 2. GEORGE ROBERTSON BLURTON November 8, 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 25, 1933 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 X M 2 □ F Days Hours Min 71 577-44-2203 April Washington, Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No College Park Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6100 Westchester Park Dr., #1015 20740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Limousine Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fanny McPherson Briscoe Clarence Harry Blurton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Genevieve Blurton - Daughter 108 Marcy Blvd., Longwood, Florida 32750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11/14/2004 Alexandria, Virginia 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licergee an 4739 Baltimore Ave., Hyattsville, MD 20781 Safall 23a. Part1. Inter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Backeremia disease or condition resulting in death) to (or as a consequence of): Cellulitis of Thich Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Endocarditis Due to (or as a consequence of): Physiclan/Medical Renal Failure IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Non Hodgkins Lymphoma 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier PATHL JAYANTI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Florest Glen Rd.

State Registrar

DHMH 17 Rev 1/200

Holy WELL

32 Registrar's Signature

Hospitul

		•	1 - For State Ragistrar	State of Maryla	nd / Depa <i>Cei</i>	artment of rtificate o	Health of Death	and Me		200 J. No.	4	37547
	Physici	an	1. Decedent's Name (First, Middle, Last)	G DEDUAD	D.G.			2.	Date of Death Month	Day	Year	3. Time of Death
	/Medic			on S. BERNAR	ກຂ				lovember		004	1:50 A M
	Examir	ner	4a. Facility Name (If not institution, give s Suburban Hospital	treet and number)			hesda			4c. County Mont	of Death Egome	ry
	Funeral Director		3.0 00 0200	M 2□F 7. Age (In yrs	: last birthday) Yrs.	Months Day		Min.	Date of Birth (Month, Day, 1		9. Birthpl Count	* -
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ecation	-				1/	Od. Inside City Limits
	Maryl f sho	ō	Maryland Montgom	ery	Rockvi	11e						1 ☐ Yes 2 📉 No
	r 28a	rec	10e. Street and Number			10f. Zip Code	9		10	g. Citizen of V	Vhat Coun	try?
	23a o	aiD	1801 E. Jefferson	St., #321		2	0852		1	Jnited	Stat	es
36	be filed within 72 hours after death with the Maryland tal Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Evertinar must be notified at	y Funeral Director	11. Marital Status  1 Never Married 27 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: ₩		Was Decedent of If Yes, specify Co 1 ☐ Yes 2 ☑ N	uban, Mexica	in, Puerto Ric	y Yes or No- an, etc.)	Blac	e - America ck, White, c	etc.
21215-0036	2 hours	Completed by	15. Decedent's Educ	eation	16a. Dece	dent's Usual Occ	cupation		16	6b. Kind of Bu	usiness/Ind	ustry
215	thin 7. e. an "n Medi	pie	(Specify only highest grade	College (1-4or 5+)	life.	kind of work dor DO NOT use ret	ired)	st of working				
	e filed within al Hygiene. I other than '	S		5+	Natio	nal Dir				ADL		
Maryland	l be fi ntal H ed otl	Be	17. Father's Name (First, Middle, Last)	1					First, Middle, Ma		e)	
3	2 should be a and Mental I is marked or raumatic eve	2	Abraham Bernar  19a. Informant's Name/Relationship (Type		19b. Mailie	ng Address (Stre			t Jose		State Zin	Code)
	and 2 sealth ar n 27 is ner trau		Ruth Bernards, Wif			E. Jeff						
ore,	of Hez item		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other p	olace)	Date	20	c. Location -		
Ē	nit. Pages partment of l ortant: If its injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☑ R.  1 ☐ Donation 5 ☐ Other (Specify)	Be	th Isra	el Ceme	tery	11/10/	'04 V	loodbri	idge,	NJ
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic ODCs.		21. Signature of Fune it Service License			rennsk 4 Carro					DC 2	0012
-			23a. Part Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the dece e cause on each line.								Approximate Interval Between
E	Physician		Immediate Cause (Final disease or condition	Pneumonia								Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse								
		20	Sequentially list conditions, if any, leading to immediate	Parkinson Due to (or as a conse		ise					-	
	licate be executed physician and sthe burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause, polisease or linjury that initiated events								_	
oʻ	an an an irial-tr	Exa	resulting in death) Last	Due to (or as a conse	quence of):							
8760	ate be hysici	dicai										
9	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 s guid be detached for use as the purishtransit if the page 2 s guid be detached for use as the purishtransit	/Mec	IF FEMALE:	Pa If was outcome of progr						1		
Вох	attending for use as	Physician/Me	in the past 12 months?	3c. If yes, outcome of pregi 1☐Live birth 2☐Fe 4☐Pregnant at time of	tal death 3[	Ectopic pregnar Other (specify)				23d. Date Mor	e of deliver	ry Day Year
o.	it the de by the tached	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	36	J Other (Specify)						
٥,	es that gned b be deta	-	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause	given in Part	l.	23e. Did toba	cco use contr	ibute to the	e cause of death?
ords	v require								1 ☐ Yes	2 XNO	3 Proba	ably 4 Unknown
Vital Records,	has be	Completed							24a. Was an autopsy	p		sy findings available appletion of cause of
E R	: The cate ha	Con							performe	ad?   d	leath?	
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:					check only one			
of	Phys this	. To	1 ☐ Yes 2X No  27. Manner of Death	1 Laynpatient 2L	ER/Outpatier 28b. Time of				5 Residen			)
lon	eath. or: After he funer	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	V	Vork? ☐ Yes 2 ☐			,,		
Division	or Attendafter death Director: / in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	reet, factory, offic	се	28f.	Location (Stre		er or Rural	Route Number,
Ö	spital or A ours after neral Dire	Cert	4 I Homodo	building, etc. (Spec	ary)				Only Or 10mm,			
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one)  (Check only one)	ician: To the best of my kr ar: On the basis of examir and manner stated.	nowledge, deat nation and/or in	h occurred at the vestigation, in m	time, date ar y opinion, dea	nd place, and ath occurred a	due to the cau at the time, dat	se(s) and mai e and place, a	nner as sta and due to	ated. the cause(s)
	To mithing to the state of the	Me	29b. Signature and title of certifier		M.D		7660		290	I. Date signed	(Month, E	Day, Year)
) [	+137		Meparaly	N NOW T	11.5	ט–2	, 000			11/	9/2	1
,	> ' ' ' ' '		30. Name and address of person who co Alpana Goswami, M.	mpleted cause of death (Ite D., 11119 Ro	em 23a) (Type, ckville	Print) Pike,	#G-100	, Rock	ville,	MD 20	0852	
	Sta Regist		31. Date filed (Month, Day, Year)  NOV 1 0 2004	32. Registrar's Sign	nature 4	Spork	20					

State of Maryland / Department of Health and Mental Hygier [ ] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 08:48 a 1 2004 Nov. Bordley Emma /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 X F 219-36-5338 Yrs. Apr. 25,1940 Maryland 64 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County the Medical Exactiner must be notified at 1 Yes 2 No Anne's MD Director Oueen Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1308 Robinson Drive 21666 USA or Iteme 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Baltimore, Maryland 21215-0036 $^{\star}$ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify þ 3 ☐ Widowed 4 ☑ Divorced **Black** "naturel" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 9 Domestic permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 Ie marked other It any injury or other traumatic event, Ita one. Worker Private Residence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hattie Robinson Roland Bordley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1602 Love Point Rd Stevensville, MD 21666 Linda Bordley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 Donation 5 Other (Specify) Robinson Cemetery 11/6/04 Grasonville, MD 22. Name and Address of Facility Henry Funeral Home, 21. Signature of Funeral Service Licensee 21613 510 Washington St. Cambridge, MD -Cenelle 94 23a. Part / Enter the disease, or complications that eausest the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) teriosclerotic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine to the Hospital or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Box 68760. by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year for 4☐Pregnant at time of death 5 Other (specify) detached P.0. 9 Unknown 9 Ni Inknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No ormed? 2 No 1 Yes of Vital 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X ER/Outpatient 3 DOA 1 🗌 Inpatient Certification: To 28c. Injury at Work? funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident the 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 T Homicide within 24 hours a To the Funeral L completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) puller 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier of death (Item 23a) (Type, Print) Davidsonville, VDNE5, MT 32. Rygistrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 5 2004

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 37549 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3:25 a.M November 2004 Mattie Brown Brotemarkle /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester 6 Dorchester Ave. Cambridge If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec. 21, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 205F Yrs. 1916 214-07-7062 Director 87 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at 1 XYes 2 □ No Dorchester Cambridge Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 Dorchester Ave. 21613 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black. White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be permit. Pages 1 and 2 should be Department of Health and Mental Important: if item 27 is marked 1 any injury or other traumatic ev. 2008. Daniel H. Wright G. Ruth Brown ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ruth Brotemarkle daughter 6 Dorchester Ave., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Memorial Park 11/13/04 Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licenses 700 Locust St., Cambridge, MD 21613 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Setween Onset and Death Immediate Cause (Final disease or condition resulting in death) ATherosclerotic heart dinan **Physician** /Medical Myelodys plastic Synchome **Examiner** Se wentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🕱 No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ģ been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25℃No Certification; To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D005659 300 Burna ST, Commanue, MD 21613 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUHAMMAD AFZAL 31. Date filed (Month, Day, Year) NOV 12 32. Regitrar's Signature 2004 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 HezeKiah 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Memoria 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Hours Year) Days Months 10 M 20 F 14-12-5836 Aug. 10, 191 Mary land Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County "natural", or Items 23a or 28e-f show Department of Health and Mental Hygiene. Importent: for Items 23a or 28e-f show importent: if Item 27 is marked other than "natural; or Items 23a or 28e-f show any Injury or other treumatic event, the Medical Experiment unit by notified at once. 1 Tyes 2 PNo Easton Completed by Funeral Director albot 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code rappe 6252 Road U5 A 1601 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Specify: Specify Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Driver 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) To Be Pages 1 and 2 should be fill ment of Health and Mental H tent: If Item 27 is marked ot! Stella (unknown homas Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 107-third Haven Heights-Easton, MD, 2/60/
pate 20c. Location - City r Town, State Blake 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Richards Mem, Park 11/13/04 Eastow, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate A □ Donation 5 □ Other (Specify) Immediate Cause (Final disease or condition resulting in death) 0x15 Physician /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last o or as a consequence of Examiner The law requires that the death certificate be executed ad by the attending physicien end detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has b autopsy page 2□ No No. 1 Yes certificate Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home Hospital: 1 Inpatient ၉ 1 🗌 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this of funeral din Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Robert Sanchez,

508 Idlewild Ave.,

Easton, MD

			i icusc	State of Marylan	d / Department of Health		voiene a a .	On 1881 DATE 1788 2
			1 - For State Registrar	otato or marytan	Certificate of Death		Reg. No. 0 4	37551
	Physici	an	1. Decedent's Name (First, Middle, La		0	2. Date of D Month	Death Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	Russell pumber	By iSCO  4b. City, Town, or Location	of Death	0 & 200 4c. County of Dea	
	Examin	er	Chesapeal		1	1	Dorc	3 f
	Funeral		5. Social Security Number 6. 5	Sex 7. Age (In yrs.	last birthday) If Under 1 Year If Under	Min. 8. Date of B		nthplace (State or Foreign country)
	Director		Usual Residence of Decedent	70	Yrs. Months Days Hours	May !	5, 1912 N	laryland
7	nylanc thow		10a. State 10b. County	10c. Cit	y, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
7	the Ma	Director	10e. Street and Number	hester	(ambridge		10g. Citizen of What C	
2	3a or	Dir	5360- A:	rev Road	2/6/	3	1/5	A
9	r death	Funeral	11. Marital Status	12. Was Decedent Ever in U			lo- 14. Race · Am Black, Wh	
36	irs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 127No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify		Specify:	lack
5-0036	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28e-f show when the Medical Exeminer must be muffled at	ted	15. Decedent's E (Specify only highest gr		16a. Decedent's Usual Occupation (Give kind of work done during mo.	st of working	16b. Kind of Business	
12	within ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)  Pastor		Parataga	stal-Church
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ylar	should be ind Mental marked o	To B	James H	Brisco	E	Ffie 1	Neekin	S
Maryland	C1 00 m		19a. Informant's Name/Relationship Samuel A. B	Турв, Print) ΥίδСО	19b. Mailing Address (Street and Numb	10		Zip Code) E. MD. 2/6/3
	s 1 and f Health Item 27 other tr		20a. Method of Disposition	20b. F	2 3 6 0 A i v e y Place of Disposition (Name of semetery, crematory or other place)	Date	20c. Location - City o	
<u>E</u>	Pages nent of ant: If It ury or o		1 12 Burial 2 □ Cremation 3 [ '4 □ Donation 5 □ Other (Speci		R. Brisco Mem. Park	11-13-04	Cambri	dee MD.
Baltimore,	permit. Departr Importa any inj		21. Signature of Funeral Service Lice		22. Name and Address of Facil	Ral Hom	e, P.A.	37
	HB = # 4		23a. Party. Enter the disease, or con	nplications that caused the deat	h. Do not enter the mode of dying, such a	TON Sti	ambridat	Approximate
	Pnysician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	takir Carcinon	av.		Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Die to (or as a conseq	uence of):	.,		5,5
	Examine.	e	Sequentially list conditions, if any, leading to immediate caus. Enter Underlying	b. — Due to (or as a conseq	uence of):			
	cuted nd ransit	Examiner	that initiated events	С.				
,092	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):			
687		edicai		d				
Box	h certi ending r use a	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta			23d. Date of de	
O.	the att	/sicia	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of d 9□ Unknown			Month	Day Year
Δ.	Physician: The law requires that the death certifica this certificate has been signed by the attending phral director, page 2 should be detached for use as It	by Physician/Med		contributing to death but not res	ulting in the underlying cause given in Part	I. 23e. Did	tobacco use contribute	to the cause of death?
rds,	w requires been sign should be		VASCULA	Denesti.	1	1	Yes 2, <del>25No</del> 3⊟F	robably 4 Unknown
eco	law requires been a 2 should	Completed				24a. Wa	opsv prior to	autopsy findings available completion of cause of
Vital Record	n: The					1 ☐ Yes		
	Physician: The lav this certificate has al director, page 2	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐		e of Death (Check only ursing Home 5 Res	one) sidence 6 □Other (Spe	ecify)
n of	ng Phy tter thi neral	on: T	27. Manner of Death 1 → Hatural 5 → Pending	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury at Work?		how injury occurred	,,
Division	death. death. ctor: A y the tu	icati	2 Accident investigation 3 Suicide 6 Could not l	De Place of Injury. At h	M 1 ☐ Yes 2 ☐ ome, farm, street, factory, office		(Street and Number or F	Rural Boute Number
<u>&gt;</u>	al or Attend s atter death l Director: / d In by the t	Certification:	4 Homicide determined	building, etc. (Specif	y)		own, State)	idia Nodis Namber,
	To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: Atter thi completely tilled in by the tuneral	ledicai (	(Check only 2 Medical Exa	miner: On the basis of examina	owledge, death occurred at the time, date a tion and/or investigation, in my opinion, de	nd place, and due to the	a cause(s) and manner a b, date and place, and du	s stated.
	o the hithin 2 of the long the	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		29d. Date signed (Mon	
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			30. Name an addr as of person who	completed cause of death (Iter	n 23a) (Type, Print)  MI) 302 Cc///R  ature	11.1	1 m1 2	11.42
	Sta	ate.	31. Date filed (Month, Day, Year)	32. Regis <b>va</b> r's Signa	Ature 207 (c///K	5 17001100	10 /110 /	1075
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			For 1 - Stata Registrar	Stat	e of Mar	yland / Dep	artment			and M	lental Hy	giene	201	O == 1== 0== 0
			Decedent's Name (First, Midd	lle, Last)							2. Date of De	ath	J   J   4 Voor	3. Time or Death
	Physici /Medio		Marshall Elwo								Novem.		79ar	1 - 1-
	Examir	er	4a. Facility Name (If not institution	-					Location of	of Death			nty of Dea	
	Funeral		Washington Co	6. Sex	7. Age (	'In yrs. last birthday	) If Under		ff Under		8. Date of Bir	Wasi	ningo 9. Bir	th county thplace (State or Foreign
Į,	Director		214-09-0166	12M 2□	l F	84 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Jan 1	<u>"1920</u>	Vir	ginia
	land ow		Usual Residence of Decedent  10a. State 10b. Count	у	1	0c. City, Town or I	ocation							10d. Inside City Limits
	B Man B-f sh Liffed	ctor	Maryland Wash	ington		Hagers	stown							1 ☐ Yes 2X No
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9	after d or Iten	Fun	1 ☐ Never Married 2 ☐ Ma	rried Arme	ed Forces? ∕es 2 XNo s, Give		If Yes, spec 1 ☐ Yes 2		n, Mexican	, Puerto	ecify Yes or No Rican, etc.)		Black, Whit	
21215-0036	within 72 hours after death with the Maryland ene. than 'natural', or Items 23e or 28e-f show he Medical Exertirer must be notified at	Completed by	3℃ Widowed 4 □ Divorce	d Year	or Dates:	140- 8	<u> </u>					Spe	cny.	
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Maryland		Be	17. Father's Name (First, Middle		_						First, Middle			
2	2 should be and Mental is marked of surnatic av	ို	Simon Fletcher  19a. Informant's Name/Relation			19b. Mai	ina Address	(Street a			Olivia al Route Numb			Zip Code)
	l and 2 ifealth arm 27 is		Lisa Terrell											a 27513
ore	of He of He If item or othe		20a. Method of Disposition  1 X Burial 2 Cremation	3 ∏Removal		20b. Place of Disp cemetery, cri	osition (Nam matory or ot	e of her place	9)	- [	Date	20c. Locatio	n - City or	Town, State
Baltimore,	permit. Pages Department of I Important: If it any injury or o		`4 □Donation 5 □ Other (	Specify)		Greenlawr				1/18			_	rt, Maryland
Ba	Dermi Depa Impo any i		21. Signature of Juneral Service	O. G	11 Op 1	7/ 1	2. Name and	a Addres	s of Facilit	y Dou	glas A.	. Fiery	Fune	eral Home
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications t	hat caused th	e death. Do not er							l, I'ld.	ryland 21742 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			SCCENO	nc (	411	101	1450	ucar	~ 1)150	-HSE	One and Dooth
	/Medical Examiner		resulting in death)	Du	e to (or as a d	consequence of):								
		Jer	Sequentially list conditions, if any, leading to immediate	b. ————————————————————————————————————	e to (or as a c	consequence of):								
	ocuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C	-									
760,	sate be executed obligation and the burial-transit	lical Ex	resulting in death) Last	Du	e to (or as a c	consequence of):								
89	The law requires that the death certificate be executed the sas been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edic		d	, , , , , , , , , , , , , , , , , , ,									
Вох	that the death certifics ed by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		, outcome of ive birth 2		□Ectopic pre	anancv					Date of de	
О.	the at	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□F	Pregnant at tim Inknown		Other (spe					'	Month	Day Year
م	res that th igned by be detac	y Ph	Part II. Other significant condit	ons contributing	to death but r	not resulting in the	underlying ca	use give	n in Part !.		23e. Did t	obacco use co	ontribute to	the cause of death?
rds	w requires been sign should be	ed by	CHRONICF	TAIA	-110	SMICCHT	701				10	Yes 2□No	3 🗌 Pr	obably 4 Unknown
Records,	e law requ has been je 2 shouli	Completed	SUBCAPS	uckn	Live	u Has	CETS				24a. Was		prior to	utopsy findings available completion of cause of
<u>س</u>			BICHTENOT	- PLEU	mer (	Frusio	26				1 Yes	rmed? 2 No	death? 1 ☐ Yes	
Vita	sician: Th certificate lirector, pag	o Be	25. Was case referred to medical examiner?	Haenital	1 Minnations	2 ER/Outpatie	at 30 00	Othe	-		n (Check only o		Mh = 1 / C = =	
o L	Attending Physician: or death. ector: After this certificaby the funeral director.	$\vdash$	27. Manner of Death	28a. [	Date of Injury Month, Day Y	28b. Time		Bc. Injury Work	4 🗆 1401	_	28d. Describe l			ciry)
Sior	or Attending after death. Director: After in by the funer	catlo	1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could	igation		injury	М		'es 2 □1	-				
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:		nined 286. I	Place of Injury puilding, etc. (	- At home, farm, s (Specify)	reet, factory,	office			28f. Location (3 City or Tox	Street and Nur vn, State)	nber or Ru	ural Route Number,
	To the Hospital or A within 24 hours affer To the Funeral Dire completely filled in b		29a. Certifier 1 Certifyi	ng Physician: T	o the best of r	ny knowledge, dea	th occurred a	t the tim	e, date and	d place,	and due to the	cause(s) and i	manner as	stated.
	the Ho nin 24 the Fu	ledical	one) // (2) (t	Examiner: On and	he basis of ex manner stated	kamination and/or i				h occurr				``
1	To To Con	Σ	29b. Signatura (notification)	er )	Mi	>	29c.	License	number			29d. Date sign	ned (Mont	h, Day, Year)
*	12		30. Name and address of person	who completed	cause of deat	th (Item 23a) (Type	. Print)	1	700	)	<i>[</i> <sub>A</sub>	11	11/6	27
1			STEPHEN E	MET	ZNEN	IM	747	Na	THE	in	ME	HAG	ENST	TERMY
	Sta Registr		31. Date filed (Month, Day, Year NOV 1	6 2004	32. Registrar's	Signature	ales				/4	16/	217	(/>
			IAOA T	0 6007	ATTERES	10					<i>V</i> •	-	-11	16

			For State Registrar	State o	f Marylan		artment of H		Mental Hygien	2 N N I.	37553
	<u> </u>		1. Decedent's Name (First, Midd	le, Last)					2. Date of Death Month D	ay Year	3. Time of Death
П	Physicia /Medic		Nancy Lee Con	don						12 2004	5:41 AM
	Examin		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City, Town, or	Location of Dea	th 4	c. County of Death	1
			Washington Cou					rstown	V	Vashingto	n County
Н	Funeral		5. Social Security Number	6. Sex 1 □ M 2 1 F	7. Age (In yrs. ) 76	last birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min	. (Month, Day, Year	r) Cou	nplace (State or Foreign untry)
	Director		219-20-4830 Usual Residence of Decedent		70	113.			June 16 19	928   Mar	yland
	land ow		10a. State 10b. County	,	10c. City	y, Town or Lo	ocation				10d. Inside City Limits
	Many Find	ţo	Maryland Wash	ington	I	lagers	town				1 ☐ Yes 2 No
	h the	Director	10e. Street and Number				10f. Zip Code		10g. C	itizen of What Cou	intry?
	th wit		11931 Heather	Drive			2174	0	t	J.S.A.	
	ems ems	Funeral	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U. orces?	S. 13.	Was Decedent of H	ispanic Origin? (	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White	
92	or It	y Fu	1 Never Married 2 Mai	If Yes, Gi	ve	-	1 ☐ Yes 2 🗙 No	Specify:	,	Specify: Wh	
Ö	d within 72 hours after death with the Maryland jiene. I than "natural", or Items 23a or 28a-f show It e Micilical Examiner must be natified at	d by	3 Widowed 4 Divorced	Year or E	ates:	16a Daga	dont's Havel Ossue.	ation	100		
21215-0036	c *_ 3	Completed	(Specify only highe	st grade completed)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	durina most of wo	orking	Kind of Business/li	ndustry
7	filed within Hygiene.  other than " ant, Ine Mes	mo	Elementary/Secondary (0-12)	College (	1-4or 5+)	Теа	chers Aid	, O	Con	intiz Saha	ol System
ō	Hyg otha ant,	a	17. Father's Name (First, Middle,	Last)		Tea	CHCIS ALO		me (First, Middle, Maide		OI AYSLEII
au	ta ta	To B	James L. Shamb	augh				Charlot	te I. Willi	ams	
Maryland	2 should be and Mental is marked sumatic av		19a. Informant's Name/Relation			1			lural Route Number, City		
	and 2 ealth a m 27 is		Robert L. Cond	on (Hus	band)			Drive H	Hagerstown,	Maryland	21740
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If itam 27 is marka any injury or othar traumatic once.		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5)		Ciata C	emetery, crei	osition (Name of matory or other plac wn Mem Pa	rk Nov.		Location - City or T Jerstown	
alti	permit. Departminite importa any inju		21. Signature of Funeral Service	Licensee	7 .	22	2. Name and Addres	s of Facility	Oouglas A. F	ierv Fun	eral Home
_	205 2 3		/ Lecunta	1 1/4	wy	1	331 Faste	rn Blvd.	N. Hagerst	-	yland 21742
		1	23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that it only one cause on	caused the death each line.	n. Do not ent	ter the mode of dyin	g, such as cardia	c or respiratory arrest,	4	Approximate Interval Between Onset and Death
	Priysician		Immediate Cause (Final disease or condition	_ a	Muno	ne,	Chunie	Oshwele	e hig Disc	ere	2-7 DAYS
į,	/Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):	1	. K	1200		YLANU
П		<u>.</u>	Sequentially list conditions,	b. Due to	(or as a consequ	neuce ot).	iller un	vivies	O Graceste	ein	1914
	ted nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>4</b> 21	Remail	Rule	w	0.			awecks.
<u>,</u>	execun and and all-tra	Exai	that initiated events resulting in death) Last	c. Due to	(or as a consequ	ue ice of):					0.000
8760	The law requires that the death certificate be executed the bas been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d							
9	tificat ig phy as th	ledi					-100				
Box	eath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna		∃Ectopic pregnancy			23d. Date of deliv	
	the att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of de		Other (specify)			Month	Day Year
P.0	that the de ad by the detached	Phy:	9 Unknown								
	res tha igned be det	by	Part II. Other significant condit	ons contributing to d	leath but not resi	ulting in the u	nderlying cause give	en in Part I.			the cause of death?
ord	w require been si should I	ted							1 ☐ Yes 2	2□No 3□Pro	bably 4 AUnknown
ecc	law ras be	ompleted							24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
<u>=</u>		Son							perförmed? 1□ Yes 2⊠N	death?	2 🗆 No
Vital Records,	Physician: This certificaral director, p	Be	25. Was case referred to medical examiner?				0.15		ath (Check only one)		71
of	hys this al dir	2	1 ☐ Yes 2 🗖 No			ER/Outpatier		4 U Nursing	Home 5 Residence		fy)
n		lon	27. Manner of Death  1. Natural 5 Pendi	iig '	of Injury oth, Day Year)	28b. Time o Injury	Worl	/at ⟨? Yes 2⊡No	28d. Describe how inju	ury occurred	
isi	uttandil death. ctor: A y the fu	icat	3 ☐ Suicide 6 ☐ Could		o of Injury - At ho	oma farm et	reet, factory, office	195 2   NO	28f. Location (Street a	and Number or Ru	ral Poute Number
Division	after Direct Jin by	Certification:	4 Homicide determ	nined 289, Flact build	ing, etc. (Specif)	()	eer, raddry, omloe		City or Town, Stai		ar Houte Hamber,
_	To the Hospital or Attanding within 24 hours after death.  To tha Funaral Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medica	Examiner: On the b	e best of my kno pasis of examination	wledge, deat tion and/or in	h occurred at the tim vestigation, in my op	ne, date and plac pinion, death occ	e, and due to the cause(surred at the time, date ar	s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the Complet	Mec	29b. Signature and title of certific		or stated.		29c. License	number	29d. Da	ate signed (Month,	Day, Year)
ı	⊢ s ⊢ ŏ		Maca	w M	D		0	46561	No		20011
	110		30. Name and address of persor			23a) (Type.	-		,	0 113	12007
2	JH.		1	RMIR	1100	- 4	maj Rom	11)	HAGBURDUN	mo	21740
	Sta	ite	31. Date filed (Month, Day, Year NOV 1	G 0004 32.F	Registrar's Signa	ture	1				
	Registi	ar	NUA T	0 2004	Breeze .	B. B.	sales				
DH	MH 17 Rev 1/2	001				-					

Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dev **Physician** Norman Lee CRUMMITT 430 AM Nov. 13, 2004 /Medical 4b. City. Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner 212 Summit Avenue, Apt. 3 Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours 1⊠ M 2□ F Yrs. 215-90-3974 42 Jan. 26, 1962 Director Maryland Usuel Residence of Decedent 10a Stete 10c. City, Town or Location 10d. Inside City Limits 10b County 1X Yes 2 □ No Maryland Washington Directo Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 212 Summit Avenue, Apt. 3 21740 IISA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: ₹ 3 Widowed 4 X Divorced white Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) residential College (1-4or 5+) Elementery/Secondery (0-12) carpenter construction 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Edward Crummitt, Jr. Peggy L. Miller 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William E. Crummitt, III -brother 5769 Sunset View Lane, Frederick, Md. 21703 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown Crematory 11/16/04 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Md. 21. Signature of Euneral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Bipolar Visorder 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 1 No þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed TI Yes ald No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 28e. Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 27. Menner of Deeth 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

**Physician** rivicaica Examiner buriel-trensit the death certificete be executed physician s the buriel Box 68760. ettending p for use es signed t Records. certificete has been si irector, page 2 should Division of Vital Attending Physician: this funeral Director: A 6 within 24 hours e To the Funeral C filled To the Hospital

ral', or items 23a or 28a-f Examiner must be notifie

Maryland 21215-0020

ltimore,

Peges nent of h Important: If I

DHMH 16 Rev 6/95

State Registrar

edicai

29a. Certifier

30. Neme end eddress of person who completed eause LAORA 31. Dete filed (Month, Day, Year) NOV 16

29b. Signature end title of certifier

of deeth (Item 23e) (Type, Print) ASITER 32. Pégistrer's Signeture

24 North Walnut St., Hogeston, MD 21740

15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

		Eng	State of Maryland / I	Department of	Health and M	ental Hygiei	O Ecgibic.	
		1 - For Stata Registrar	•	Certificate o		Reg.		37555
		1. Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
Physic /Medi		William Franklin C				Doxmber	11 2004	22:48 M
Exami	ner	4a. Fecility Name (If not institution, give s		100	n, or Location of Death		4c. County of Deal	
		Washington County  5. Social Security Number 6. Sex	Hospital 7. Age (In yrs. last bi	Hagers			Vashingto	
Funeral Director			M 2□F 78	Yrs. Months Day	ys Hours Min.	8. Date of Birth (Month, Day, Ye. June 23, 1	ar) 9. Birt	hplace (State or Foreign buntry) Vork
P .		Usual Residence of Decedent				ounc 25,1	1)ZO fiew	
anylar show	_	10a. State 10b. County	10c. City, Tow	vn or Location				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M	Directo	Maryland Washington 10e. Street and Number	n Hagers	S town 10f. Zip Code	<u> </u>	100	Citizen of What Co	
ified within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene.  Ither then "naturel", or items 23e or 28e-f show ont, the Medical Examinat must be notified at			Ant 2/0					outray ?
death ms 2:	Funeral	20009 Rosebank Way	2. Was Decedent Ever in U.S.	13. Was Decedent of	of Hispanic Origin? (Spe	cify Yes or No-	A. 14. Race - Ame	
after or Its	F	1 Never Married 2 Married	Armed Forces? 1√7Yes 2 ☐ No If Yes, Give	1 Tes, specify C	uban, Mexican, Puerto F No Specify:	Rican, etc.)	Black, White	
urel:	d by	3 Widowed 4 Divorced	Year or Dates:	71			Specify Whi	
n 72	Completed	15. Decedent's Educ (Specify only highest grade	completed)	<ol> <li>Decedent's Usual Occ (Give kind of work do: life. DO NOT use ret</li> </ol>	ne during most of working	16b.	. Kind of Business/	Industry
I with	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	sembler		N	lanufactu	ring
Lal y latter A LA.  2 should be filed within and Mental Hygiene.  1e marked other then eumatic event, the Mental and Mental and a Menta	Be C	17. Father's Name (First, Middle, Last)	'		18. Mother's Name	(First, Middle, Maid		
should be nd Mental marked c	10	William Patrick Car	nnon		Dorothy R	uth Conne	tt	
ie, ividifyidity ZIZIOOOOO  s 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. Item 27 le marked other then "naturel", or Items 23e or 28e-f show tiem 27 le marked other then "maturel", or Items be notified at		19a. Informant's Name/Relationship (Typ	e, Print) 19t	b. Mailing Address (Stre	eet and Number or Rural	Route Number, Cit	y or Town, State, Z	Zip Code)
1 and 1 and Health em 27 ther tr		Clara Marie Cannon  20a. Method of Disposition		20009 Rosebart Disposition (Name of	ank Way Apt		rstown M. Location - City or	
Pages nent of I		1 Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	emoval from State cemete	ery, crematory or other p	olace)			
		21. Signature of Funeral Service Licens		22. Name and Add	tery   11/16			
permit. Departr Importe eny inji		1 - 15	~~	1900 SS	kes sylvania Av	t Haven H		
1000		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death. Do					Approximate Interval Between
Physician	ı	Immediate Cause (Final disease or condition	Acules	my 1) Corch	el wlar	ction		Onset and Death
/Medical Examiner	П	resulting in death)	Du to (or as a consequence	of): 1 - t	al.	4 4		11511
THE OWNER OF THE OWNER OWNER OF THE OWNER OWN	Į.	Sequentially list conditions, if any, leading to immediate	Due to for as a consequence	7 140	en ou	sau		17 Jears
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Atherica	Chron S	- Cliner	distil		
an an	Exa	resulting in death) Last	Due to (or as a consequence	of):	(	5		
ate be executed hysician and the burial-transit	lical	d						
eath certifica attending pt for use as t	Med	IF FEMALE:	to Maria autooma of progression					
attenc for us	lan	in the past 12 months?	Ic. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death	a 3 ☐Ectopic pregnar			23d. Date of deli Month	very Day Year
that the de ned by the a	Physician/M	1 Yes 2 No 9 Unknown	9□ Unknown	Other (specify)	·			
res that rigned b	by Pt	Part II. Other significant conditions conf	ributing to death but not resulting i	in the underlying cause	given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
w require		- fyrerteric	٧٠٠			1 🗆 Yes	2 No 3 Pro	obably 4 Unknown
e taw re has be	ompleted	Bucheles me	lliki			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
The t	Con					performed	death?	
ding Physicien: The h. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	ospital:		26. Place of Death	(Check only one)		
Phys this	5 T	1 Yes 2 No	1 Inpatient 2 ER/O	utpatient 3 DOA		e 5 Residence		cify)
ding th. After	tion	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury V	Vork? ☐ Yes 2 ☐ No	od. Doddibo now in	july occurred	
VISIC VISIC	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, offic	ce 2	8f. Location (Street		ral Route Number,
rs affe	Cert	4   Nothicide	building, etc. ( <i>Specily</i> )			City or Town, Sta	110)	
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ical	(Check only 2 Medical Examin	cian: To the best of my knowledge er: On the basis of examination an	e, death occurred at the	time, date and place, ai y opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
o the ithin 2 o the	Medical	295. Signature and title of certifier	and thanner stated.		ense number		Date signed (Month	
		1	MIDMO		23623			
24441		3 Name and address of person who cor	npleted cause of death (Item 23a)	(Type, Print)	^	1000	icm ru	trun mi)
24		Frederic It 10	KS III MA III	10 med	ud lenge	us Rd	1 tejus	trun mi)
St	ate	31. Date filed (MonNOV Yar6 200	32. Registrar's Signature	Aneiles			•	-

	Decedent's Name (First, Middle  EDWARD	o, Last)  JAMES	CAIN	т		2. Date of De.	Dav	2004	3. Time of Death
Medical aminer	4a. Facility Name (If not institution		CAIL	4b. City, Town, or I	ocation of Death	NOV.	8 4c Cou	ZUU4	10:50 AM
ammer	TALBOT HOSPIC				ASTON	,		ALBOT	•
al	5. Social Security Number	6. Sex 7. Age (l)	'n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h v. Year)	9. Birthp	place (State or Foreig
	218-36-3233 Usual Residence of Decedent	65	Yrs.			JULY 4	, 1939	MARY	YLAND
	10a. State 10b. County	10	Oc. City, Town or Lo	cation			<del></del>	1	10d. Inside City Limits
Director	MD TALE	вот	EASTO	N					1X Yes 2 ☐ No
Dire	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
<b>Funerail</b>	#8 LONDONDERE		110	21601			USA		
5	11. Marital Status 1 ☐ Never Married 2 Marr	12. Was Decedent Eve Armed Forces? ied 1 11 Yes 2 1 No	or in U.S. 13. 1	Was Decedent of His f Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. F	Race - Americ Black, White,	
2	3 ☐ Widowed 4 ☐ Divorced	ied 1 <b>X</b> Yes 2 □ No If Yes, Give Year or Dates: <b>19</b>	56-1960	1 ☐ Yes 2X No	Specify:		Spe	cify: WE	HITE
ered	15. Decedent (Specify only highes		16a. Deced	dent's Usual Occupat	ion iring most of wor	kina	16b. Kind of	Business/Ind	dustry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done du DO NOT use retired)				_	_
e ငိ	12 17. Father's Name (First, Middle,	Last)	ENGI	NEER	I8. Mother's Nam	ne (First, Middle,	Maiden Sum	ROAD	OS
To Be	JOHN EDWARD O				JENNIE				
-	19a. Informant's Name/Relations	hip (Type, Print)	19b. Mailir	ng Address (Street ar				vn, State, Zip	Code)
	ELAINE K. CAIN/			NDONDERRY	, EASTON	I, MD 21	601		
	20a. Method of Disposition  Burial 2 Cremation		20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)		Date	20c. Locatio	n - City or To	own, State
	`4 □ Donation 5 □ Other (S <sub>i</sub>	and the second s		RY CEMETE				LK, MD	
	21. Signature of Funeral Service		FE	Name and Address	of Facility FENBEIN	& NEWNAI	M FUNE	RAL HO	ME, P.A.
	23a, Part1, Enter the disease, or	. MERCER	(3~ ZU	U S. HAKK	ISON ST.	EASTO	N, MD	21601	Approximate
	Immediate Cause (Final	only one cause on each line.	•			or roopmatory are	001,		Interval Between Onset and Death
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1	resulting in death)	a. Due to (or as a co	onsequence of):	inomer	- ne	astat	ic		Lypar 3mo
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The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, the Hospitel or Attending Physicien:

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 1/2001

death.

overtiking.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. Vicken Pooemkian, M.D. 8118 Good Luck Road, Lanham, MD

VICKENI

√icken Pooemkian, M.D.

1 0 2084

31. Date filed (Month, Day, Year)

NOV

003472

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 37558 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 10, 2004 **Physician** Robert James Cochrane 12:19p M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 10270 Quail Creek Place Ijamsville Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jul 18, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 579-40-9274 Washington, DC 72 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Frederick Maryland Ijamsville 1 ☐ Yes 2X No Director 10e. Street and Number 10270 Quail Creek Place 10f. Zip Code 10g. Citizen of What Country? 21754 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ ¥¥Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet College (1-4or 5+) Elementary/Secondary (0-12) C.P.A./Treasurer Financial Institution 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Cochrane James Sr Ruth Irene Hartman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane M. Figgins/ Daughter 10270 Quail Creek Place, Ijamsville, MD 21754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Gate of Heaven Cemetery Nov 15,2004 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Lice <sup>22.</sup> Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Due to (or as a con equence of): disease or condition resulting in death) Years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Leads of ir jury) that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 4□Pregnant at time of death ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 👿 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D51610 November 11, 2004 ~~ MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Tolino, M.D., 1475 Taney Avenue, Frederick, Maryland 21702-5127 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 2 2004 Registrar

DHMH 17 Rev 1/2001

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

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The law requires that the death certificate be executed

To the Hospital or Attanding Physician:

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Division of Vital Records, P.O. Box 68760

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attending physician a for use as the burial-

page 2 s

funeral

After

Director: /

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Baltimore, Maryland 21215-0036

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State of Maryland / Department of Health and Mental Hygie ( )

1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death OCC 27, Day 2004 **Physician** Catherine Dartoozos 9:45 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 🕱 F 88 Director Sept.27,1916 Greece 577.74.9220 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ortant: if tiem 27 is marked other then "neturel; or items 23a or 28a-f show injury or other treumatic event, the Mudical Examinater must be notified at a. MD Montgomery North Potomac 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11424 Saddleview Place 20878 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "neturel", or itel 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give Year or Dates: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurateur Business Owner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alexander Kokalis Evanthia Flamos 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other tree Miltiades Dartoozos / Son 8313 Ashwood Drive Alexandria, VA 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov.1,2004 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 21. Signature of Fundial Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue NW WDC 20016 23a. Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ASPIRATION NEUMONIA 5 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physicien Physician/Medical the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2 No Month Day Year 5 Other (specify) 4☐ Pregnant at time of death Division of Vital Records, P.O. the a 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Cerebrovascular Infarction Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy 24 No 1 🗌 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only оле) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐No Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) Nov. 8, 2004 29c. License number 29b. Signature and title of certified D0061681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Dr. Rockville, MD Robert Kirkaldy, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 1 0 2004 NOV

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State of Maryland / Department of Health and Certificate of Death		Reg. No.	U
State of Maryland / Department of Health and	Mental	Hygiene	0

Physici /Medic Examin	al
Funeral	

FERRANTE, MATTEW

use as the burial-transit the attending physicien

Division of Vital Records, P.O. Box 68760 Hospital or Attanding Physician: 4 hours after death. Funeral Director: After this certifica To the Hospital
within 24 hours a
To the Funeral C

3. Time of Death 1. Decedent's Name (First, Middle, Last) Wember Day Year 7:55 DM MATTHEW JOSEPH FERRANTE 10 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Prince George's Lanham | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, July 29, July 29, 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Italy 92 115-12-6785 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Director Prince George's Riverdale Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5806 66th Avenue 20737 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 No 1942 If Yes, Give
Year or Dates: 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglene Important: If Item 27 ie marked other tha any njury or other traumatic event, Italy once. Truck/Bus Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Felice Ferrante Raffaela Cardascia ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eugenia Ferrante - Wife 5806 66th Avenue, Riverdale, Maryland 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 11/11/2004 Alexandria, Virginia \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL Enysician INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed RENAL 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 20 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058275 11-11-04 Parand Marie MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 GOODLUCK Rd LANHAM HOSPITAL DOCTORC COMMUNITY PARAND ALAVI, MD MD 20706 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Registrar

NOV 1 2 2004

			For State Registrar	State of Marylan	,	irtment of H		•	giene 0 (	)4	37562
			Decedent's Name (First, Middle, Last,	)				2. Date of Dea	ıth		3. Time of Death
	Physici /Medio		MARY RUTH FRY					Novemb	er 9, 20	004	9:00 A.M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of	Death	4c. County	of Death	
			22 Ridge Road, T			Greenb		(1) to 1 a 2 a 2 a 2 a 2 a 2 a 2 a 2 a 2 a 2 a			rge's
	Funeral Director		5. Social Security Number 6. Sec. 15 216-22-0456	7. Age (In yrs. 78	last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of Birt (Month, Da March 1	, Year)	Country	ce (State or Foreign y) eville, MD
	aryland show	10	Usual Residence of Decedent  10a. State 10b. County		y, Town or Lo					100	d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th the M or 28a-f	Director	Maryland Prince C	George's G	reenbe	10f. Zip Code			10g. Citizen of V	/hat Country	
	23a	rai	22 Ridge Road, T				20770		U.S.A.		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene, item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examinat must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No !f Yes, Give Year or Dates:	ł.	77	ispanic Origir In, Mexican, I Specify:	n? (Specify Yes or No Puerto Rican, etc.)	14. Race Blac Specify	e-Americar k, White, et Whit	C.
21215-0036	in 72 hou n "natura Nedical E	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	lent's Usual Occup kind of work done o OO NOT use retired	durina most a	of working	16b. Kind of Bu		
212	filed within Hyglene. ethar than "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Secre	tary			Cemete	ry	
Maryland 3	12 should be filed within h and Mental Hyglene. 7 Is marked othar than "traumatic event, the Max	To Be C	17. Father's Name (First, Middle, Last)  Trube Terry Bour	ne				s Name <i>(First, Middle,</i> ma C. Gill		θ)	
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (T)		19b. Mailir	g Address (Street	and Number	or Rural Route Numbe	r, City or Town,	State, Zip C	ode)
	and 2 salth a n 27 ls		Dr. Robert W. Fry				ve, Pl	attsburgh,			
ore	of He of He if itam		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	emetery, crer	sition (Name of natory or other place		Date	20c. Location -	•	
Ĕ	Pages ment of tant: If it jury or o		`4 ☐ Donation 5 ☐ Other (Specify)	Fo				1/12/2004			
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important; If item 27 Is any injury or other trau once.		21. Signature of Funeral Service Licens	ee Vare				Gasch's F Ave., Hyat			
8760,	death certificate be executed  Ex  Page 11 of the continuation of	dicai Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Upper Gastro Due to (or as a conseq b. Due to (or as a conseq c. Due to (or as a conseq d	uence of): uence of):	inal Blee	ed				nterval Between Onset and Death
O. Box 6	es that the death certific igned by the attending p be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)	,		23d. Dat Mor	e of delivery oth D	r Pay Year
Д	w requires that the been signed by th should be detache	ed by Ph	Part II. Other significant conditions co	•	-				obacco use contr ′es 2⊠No		cause of death?
Division of Vital Records,	e law has b	Completed by	Hypertension, Hyp	oothyroidism,	Chroni	c Renal		24a. Was autop perfo 1 Yes	med? p	Vere autops rior to comp eath?	ey findings available oletion of cause of
ta	iclan: Th certificate rector, pag	Bec	Insufficiency 25. Was case referred to medical				26. Place o	of Death (Check only o			
<b>1</b>	Physiclan: r this certifica and director, i	ToE	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	t 3 DOA Oth	er: 4 □ Nurs	sing Home 5 🛣 Resid	ence 6 🗆 Othe	er (Specify)	
ion o	fte fre	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2∐No		ow injury occurr	ed	
Divis	al or Atta s after des I Directo d in by th	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and Numbern, State)	er or Rural F	⊰oute Number,
	To the Hospital or Attandi within 24 hours after death. To the Funaral Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one)	vsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, deat ation and/or in	n occurred at the tirvestigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time,	cause(s) and ma date and place, a	nner as stat and due to th	ed. ne cause(s)
	withir To th comp	Me	29b. Signature and title of certifier	M		29c. Licens	e number		29d. Date signed	(Month, Da	iy, Year)
Λ			- H.	1 5.5		D	55559		Novemb	er 10	, 2004
*	- (1)		30. Name and address of person who of Thomas E. Maslen,				rive,	Ste. 316,			
	St Regist	ate	31. Date filed (Month, Day, Year)  NOV 1 2 200	3 Registrar's Signa	ature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov. **Physician** 8,2004 5:20 M Samuel R. Frank /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital 7. Age (In yrs. last birthday)

9. Birthplace (State or Foreign (Month, Day)

9. Birthplace (State or Foreign (Month)


9. Birthplace (Month)

. Social Security Number 6. Sex **Funeral** 1**⊠**M 2□F 208-09-2666 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Itams 23a or 28a-1 object. By Marked by Injury or other treumatic event, Its Marked by Injury or other treumatic event. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Rockville Md. Montgomery 1 XYes 2 No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 USA 9701- Veirs Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 XNo 1 Never Married 2 Married Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lutheran Pastor Ministry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Sumame) S. Roy Frank Carrie Parks 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 9701-Veirs Dr., Rockville, Md. 20850 19a. Informant's Name/Relationship (Type, Print) Rev.Dr.Reichard-Executor 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State 11/18/2004-Lewisburg, Pa. Lewisburg Cem. <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility m Hysong Co., Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest shock, or heart failure. List only one caused each line. Wash., DC Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Xunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 📉 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel D 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifler 29c. Ligense number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (I) 23a) (Type, Print)

Dr. William Dooley- 9901 Medical Center Dr., Rockville, Md. 20854 31. Date filed (Month, Day, Year) 2. Registrar's Signature State NOV 1 2 2004 Registra

			1 - For State Registrar	State of Marylar		tment of He			2001	27561
	0.		Decedent's Name (First, Middle, La	st)	007.			2. Date of Deat Month	n Day Year	3. Time of Death
	Physici /Medio	cal	Richard Leonard	<del></del>				77	13 200	4 0326
	Examir	ner	4a. Facility Name (If not institution, giv	o street and number)	792	4b. City, Town, or Lo	S TOIL		4c. County of Dea	BOT
	Funeral Director		217-30-0722	Sex 7. Age (In yrs. 1 ☑ M 2 ☐ F 69			Hours Min.	8. Date of Birth (Month, Day, April 8	9. Bir (20 1935 Mar	tholace (State or Foreign ountry) y Land
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Loca	ition				10d. Inside City Limits
)	d within 72 hours after death with the Maryland jiene. r than "neturel", or Items 23a or 28a-f show the Madical Examinet must be redified at	ctor	Maryland Queen An	ne's Que	enstown					1 ☐ Yes 2X No
)	vith the	Funeral Directo	10e. Street and Number	1		10f. Zip Code		10	og. Citizen of What Co	ountry?
	ns 23s	eral	1406 John Brown R	12. Was Decedent Ever in U	J.S. 13. Wa	21658 as Decedent of Hisp	panic Origin? (Spec	cify Yes or No-	USA 14. Race - Ame	erican Indian,
			1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give	li Y	es, specify Cuban,	Mexican, Puerto P	tican, etc.)	Black, White	e, etc.
3-003b	hours turel',	ed by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	nt's Usual Occupation				White
<u>.</u>	hin 72 8. 8n "ne Madic	Completed	(Specify only highest gra Elementary/Secondary (0-12)		(Give kii	nd of work done dun NOT use retired)	ning most of working	9	6b. Kind of Business	
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Ä	m = 0 \$	o Be	17. Father's Name (First, Middle, Last Leonard Joseph F				8. Mother's Name Dorothy		,	
Mary	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked eny injury or other treumatic ev <u>once</u> .	F	19a. Informant's Name/Relationship (		19b. Mailing				City or Town, State, 2	Zip Code)
S oî	l and 2 lealth im 27 i	1	William A. Davis				, LaPlata		Land 20646	
baltimore,	ages int of H		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation, 5 ☒Other (Specie			ion (Name of tory or other place) Mom Cand			ebron, Mar	
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	ding Ph h. After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28		v injury occurred	
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2	s after s after al Dire	Certification:	4 Homicide determined	building, etc. (Special	fy)	,,,,		City or Town,	State)	
	To the Hospitel or Attenwithin 24 hours after deating the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Example (Check only one)	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death o ation and/or inves	ccurred at the time, stigation, in my opini	date and place, an ion, death occurred	nd due to the can d at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	1		29c. License no	umber 9481		d. Date signed (Montl	
			John Sartsu		n 23a) /Tuno Pri		7401		11-13-04	
			John Botsis, M.D.				ston, MD	21601		
•	Sta Registi	ate rar	31. Date filed (Month, Day, Year) NOV 15	2004 32. Registrar's Signa	ature	parte				

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Howard Dobbin Gibson, Jr. 11 07 2004 7:37p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 22761 Almost Neavitt Rd. Bozman Talbot If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth 1 Month Pay Year) 3 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 1**∑**M 2□F 215-30-7496 71 Baltimore, MD Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 21612 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No Specify: SpecifyWhite 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore County Office Clerk <u>Police Dept.</u> 18. Mother's Name (First, Middle, Maiden Sumame) Doris Elizabeth Happersett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22761 Almost Neavitt Rd. Bozman, Md. 21612 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Greenmount Cem. 11-11-2004 Baltimore, MD. 22. Name and Address of Facility Carroll Hurley Funeral Home, PC 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as dardiac of respiratory arrest. 25, Md. 21,000 mate shock, or heart failure. List only one cause oppeach line. Interval Between Onset and Death sol money On will 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 12 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? res 2 P No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) H4258 11-8-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell A. Schilling DO 555 Cynwood Dr., Easton, Md. 21601

DHMH 17 Rev 1/2001

State

Registrar

**Funeral** 

Director

32. Registrar's Signature

NOV 1 0 2004 DOGGO

			1 - For State Registrar	State of Maryla		artment of rtificate o			iene 004	37566
	Physic /Medi		Decedent's Name (First, Middle, Las     ELLEN ELIZABETT		GLADDIN	īG		2. Date of Death Month	-	3. Time of Death
	Exami		4a. Facility Name (If not institution, give Hartley Hall Nurs 5. Social Security Number 6. Se	sing Home	s. last birthday)	Pocomok		ath	4c. County of Deat	r
	Director		213-24-4710 Usual Residence of Decedent	□ M 2ÅF	74 Yrs.	Months Day	s Hours Mir	8. Date of Birth (Month, Day, April 7	, 1930 Ma	hplace (State or Foreign untry) ryland
	vith the Maryla or 28a-f shou be notified at	Director	MD Worceste  10e. Street and Number	er Poo	comoke	City 10f. Zip Code		10	g. Citizen of What Co	10d. Inside City Limits 1 Y Yes 2 □ No untry?
36	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or Items 23e or 28a-f show event, the Modical Examiner must be notified at	by Funeral Director	1102 Cedar Street  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		21851 Was Decedent of If Yes, specify Cu	f Hispanic Origin? ( uban, Mexican, Pue o Specify:	Specify Yes or No- rto Rican, etc.)	USA  14. Race - Amer Black, White  Specify:	o, etc.
21215-0036	within 72 hou ane. Ithan "natural ie Mudical El	Completed t	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0·12)	ucation de completed) College (1-4or 5+)	(Give	DO NOT use reti	e during most of we	orking 1	6b. Kind of Business/I	hite <sub>ndustry</sub>
Maryland 2	ed at b	To Be Co	12 17. Father's Name (First, Middle, Last) Daniel Hargis Bra	4 adford	Homem	aker		me (First, Middle, M e Parks	Domestic  Jaiden Sumame)	
re, Mary	1 and 2 s Health ar em 27 ts ther trau		19a. Informant's Name/Relationship (TH. Coston Gladding) 20a. Method of Disposition	(Husband)	1102_	Cedar St	Pocom	oke City,	City or Town, State, Zi  MD 21851  Oc. Location - City or T	
Baltimore,	permit. Pages Department of I Importent: If its any injury or o		1 M Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify.  21. Signature of Funeral Service License	Sal	em Metho	natory or other pl dist Cemet Name and Add 1 IOWAY 1	ery 11/1		ocomoke Ci	
	Enysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	dications that caused the deapne cause on each line.	th. Do not ent	3 Linder of the mode of the	1 Ave., Poying, such as cardia	ocomoke Ci	ity, MD 218	Approximate Interval Between Onset and Death
8760,	Medical Examiner Associated and price pric	Ical Examiner	resulting in death)  Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.)		700 2				5-days
O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feti 4 Pregnant at time of 9 Unknown	aldeath 3□	Ectopic pregnan	су		23d. Date of deliv	ery Day Year
ords, P.	law requires that the as been signed by th 2 should be detache	ρχ	Part II. Other significant conditions co	ntributing to death but not re	sulting in the ur	nderlying cause g	iven in Part I.		cco use contribute to t	he cause of death?
al Reco	The ate h page	Completed	05 W.					24a. Was an autopsy performe	prior to co death? ≰No 1 ☐ Yes	opsy findings available impletion of cause of
Division of Vital Records,	S S	atlon: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No  27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju	ther: 4 Nursing H	ath (Check only one) Home 5 Residence 28d. Describe how	ce 6 □Other (Specia	59)
Divis	in ite	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	fy) 			City or Town,		
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or inv	estigation, in my	opinion, death occu	irred at the time, date	and place, and due to	the cause(s)
)	With Con	~	29b. Signature and title of certifier	ral, MI	>	05	se number 54422		Date signed (Month, $11-8-2$ )	· ·
2.1	4.6		30. Name and address of person who co	et Sto:	Por	DMAKI	E : MI	2185	51	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 2 20	32. Régistrar's Signa	diure	adi				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 37567 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Fannie Guess 9, 2004 /Medical Nov. 10:30 a. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Larkin Chase Nursing Home Prince Georges Bowie If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 578 36 9913 1 ☐ M 2**X**☐ F Months 78 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location in then "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits Director D.C. Washington 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 764 Gresham Place, N.W. 20001 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e any injury or other treumatic event, the Medical France ODEs. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: ፩ 3 → Widowed 4 □ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chief W.H.C. 6 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Barry Boyd Cornelia Spencer ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Talley / Son 5602 Delaware Dr. Forrest Heights, MD. 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Memorial 11/13/04 Suitland, MD. 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Rhines Funeral Home 3015 12th St., N.E. Wash., D.C. 20017 23a. Part. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastati Physician ( /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death signed by the a 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ icate has been sig , page 2 should b 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes Hospitel or Attending Physicien: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? after death. | Director: After 1 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide 24 hours a fts Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou To the Fune completely fi Medical (Chack only one) 29b. Signature and tittle of contifier 29d. Date signed (Month, Day, Year) 11/10/04 of person who completed cause of death (Item 23a) (Type, Print) 4-15 Gelge PK MD 20740 6201 tred OKWARA Greenhelt 31. Date filed (Month, Day, Year) NOV 1 2 2004 82. Registrar's Signature State Registrar

			1 = For State Registrar					Health and M f Death		Reg. N2 () [	14	37568
	Physic	ian	Decedent's Name (First, Middle, La.	•					2. Date of D Month	eath	Year	3. Time of Death
	/Medi	cal	LAUSELL GALLOWAY  4a. Facility Name (If not institution, give			41	City Taylor	and position of Doort	NOVEM	BER 09, 2	2004	9:06P M
	Examir	ner	SOUTHERN MARYLAN	,	L CENTER	- 1	-	or Location of Death		4c. County		GEORGES
	Funeral		5. Social Security Number 6. S		e (In yrs. last bir	thday) If	Under 1 Yea		8. Date of Bi (Month, D	irth lay, Year)		lace (State or Foreign
,	Director		Usual Residence of Decedent		63	Yrs.			AUG. (	05, 1941	VIR	GINIA
)	arylan show	_	10a. State 10b. County		10c. City, Tow						11	Od. Inside City Limits XX Yes 2 □ No
	death with the Maryland ims 23a or 28a-f show r must be multired at	Director	MARYLAND PRINCE  10e. Street and Number	GEORGES	TEMPLE		S Of. Zip Code			10g. Citizen of W	/hat Coun	
l	th with	a Di	4004 21ST PLACE					0748		UNITEI		
10	tems tems	Funeral	11. Marital Status	12. Was Decedent Armed Forçeş?		13. Was		Hispanic Origin? (Spe ban, Mexican, Puerto	ecify Yes or N Rican, etc.)		- America	an Indian,
336	within 72 hours after ane. then "naturel", or Ite	þ	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes XXXII If Yes, Give Year or Dates:	No		Yes XX N				BLA	
215-0036	72 hou	Completed	15. Decedent's Ec (Specify only highest gra	lucation de completed)	16a.	Decedent	's Usual Occi	upation e during most of worki	ing.	16b. Kind of Bu	siness/Inc	lustry
121	within ane. then "	mp	Elementary/Secondary (0-12)	College (1-4or 5	,	life. DO l	VOT use retir	red)	3	DD		
, 1d 21	I Hygir other	Be Co	17. Father's Name (First, Middle, Last)		HEA	VY EC	UTPME	NT OPERATO  18. Mother's Name		PRIVA e, Maiden Sumam		
Maryland	ould be Mental arked c	To B	LAUSELL GALLOWAY					ESSIE	C. DOWE	PΥ		
re, Maryland 2	d 2 sh th and 7 Is m treum		19a. Informant's Name/Relationship (					et and Number or Rura				Code)
re,	s 1 and the Heal		20a. Method of Disposition	/ WIFE	20b. Place of	Dispositio	ST PL. n (Name of ry or other pl		HILLS,	MD 2074 20c. Location -		wn, State
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Importants if item 27 is marked other then "naturel", or items 23a or 28a-f show any lojury or other treumatic event, the Medical Exeminar must be notified at once.		1 ☐ Burial ※ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		1	OLITA	N CREN	MATORY 11/2				
Balt	permit. Depart Import any Inj once.		21. Signature of Fun ral Service Licen	see 0 0 A		22. Na MAR	me and Add	S FUNERAL	HOME C	F MARYLA	ND,I	NC.
			23a. Part 1. Enter the disease, or comp	plications that caused	the death. Do r	430	O POTI	LLAND KOAD	SULT	LAND, MD	207	46 Approximate
	Physician		shock of heart failure. List only immediate cause (Final disease or condition	one cause on each in		ANO	ER.					Interval Between Onset and Death
	/Medical Examiner		resulting in death)	A / A	a consequence			vamous	011	0 00107	7)	
		er	Sequentially list conditions,	b. VOC	a consequence (	URD	SQ	DIMMORZ	CELL	- Chive	K	
	ecuted and transit	aminer	cause. Enter Underlying Cause (Disease or injury that initiated events	c							4	
60,	licate be exe physician ar s the burial-t	m	resulting in death) Last	Due to (or as	a consequence o	of):						
687	ticate I physics the b	Physician/Medical		. d								
X	death certitics attending pl	M/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2  Fetal death	3 □ Eat	opic pregnanc	av.		23d. Date	of deliver	у
D. B	ne deat the att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown			ner (specify)			Mon	th I	Day Year
Э.	that the de led by the a detached t	y Phy	Part II. Other significant conditions of	ontributing to death be	ut not resulting in	the under	lying cause g	iven in Part I.	23e. Did t	tobacco use contri	bute to the	e cause of death?
rds	w requires tha been signed should be del	ed by	HYPERTENSION						1 🗆	Yes 2□No	Proba	ably 4 Unknown
eco	e law re has bee je 2 sho	Completed							24a. Was		ere autop	sy findings avaitable
al R	i <b>cien</b> : The l certificate ha rector, page								perfo 1 ☐ Yes	ormed? de	ath?	
Zi.	ysicien: is certifica director, i	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ER/Out	trationt 2	□ DO4 Ot	26. Place of Death ther: 4 Nursing Hon			. (0	
Division of Vital Records, P.O. Box 68760,	Attending Physicien: The law requires that the death certilicate be exerceath.  r death.  or the this certilicate has been signed by the attending physician a given the tuneral director, page 2 should be detached for use as the burial.	$\vdash$	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injur (Month, Day			28c. Inju	ury at 2		how injury occurre		
Siol	Vttendir death. ctor: Af y the tur	catic	2 Accident investigation 3 Suicide 6 Could not be			M	/ 1 <u></u>	Yes 2 No				
Divi	F F F C	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, far c. <i>(Specify)</i>	rm, street, i	actory, office	2	8f. Location (. City or To	Street and Numbe wn, State)	r or Rural	Route Number,
	To the Hospitel of within 24 hours at To the Funerel D completely tilled is		29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exam	ysician: To the best of	of my knowledge	, death occ	urred at the t	time, date and place, a	and due to the	cause(s) and man	ner as sta	ted.
	the Hin 24 the Figure 1	Medical	une)	and manner sta	ited.	wor investi		opinion, death occurre				
	To With		29b. Signature and title of certifier	SURESH V	ENCHERE I	PHYCH			2	29d. Date signed	(Month, D	oth soul
0 1	(10)		30. Name and address of person who o	completed cause of de	eath (Item 23a) (	Type, Print	)	D005378 + 101 ,		140	, ,	
N (	17		11701 LIVINGS	TON D	CIVE	San	TC +	キーハー	T-NOT	1. 1Alian	11-11	(1114

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1170 | LIVING STON DRIVE SUITE # 101

31. Date filed (Month, Day, Year)

NOV 1 2 2004

			Please	State of Maryl				•	•	
			For State Registrar	Clate of Mary		rtificate of			a. 2004	37569
	Physicia	an	1. Decedent's Name (First, Middle, Last,	riffin				2. Date of Death Month		3. Time of Death
	/Medic	al	Charles S. G			4h City Town o	r Location of Death	Nov.	7, 2004 4c. County of Dec	7:45p <sup>M</sup>
	Examin	er	5620 Serenity L			Marbu			Charle	
	Funeral		Social Security Number 6. Sec.		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign Country)
	Director		418-36-5797 Susual Residence of Decedent	71	113.		l N	March 26	,1933	AL
	arylan show	_	10a. State 10b. County 10b Charl	1	city, Town or Lo Mart					10d. Inside City Limits 1 ☐ Yes 3/3/No
	tha M 28a-1	recto	10e. Street and Number	,65	riali		10	g. Citizen of What C		
	filed within 72 hours after deeth with the Maryland Hydiona. ther than "natural", or items 23s or 28s-f show int, the Machell Examination nust be notified.	Funeral Director	5620 Serenity L	ane		10f. Zip Code 206	58		USA	
	er dee itams net m	uner	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
	al, or	by	3 Widowed 4 Divorced	No Yes 2 □ No Yes, Give Year or Dates:		1 ☐ Yes 2 📉 No	Specify:		Specify:	White
5	"natur	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work	king 1	6b. Kind of Busines	s/Industry
717	s within liena. r than	ошо	Elementary/Secondary (0-12)	Coilege (1-4or 5+)		chanic	"		Aut	0
2	be filac tal Hyg d othe	Be	17. Father's Name (First, Middle, Last)	riffin			18. Mother's Nam	e (First, Middle, Maria Alice	Meems	
yla	2 should be filad within and Mental Hygiena. Is marked other than sumatic event, the Maramatic event.	2	James Louis G:		19h Maili	no Address (Street			City or Town, State,	Zin Code)
	s 1 and 2 should be filad within 72 hours after deeth with tha Marylan if Healinh and Mental Hygiens. I the man 28a or 28a-1 show filem 27 is marked other than "natural", or itams 28a or 28a-1 show other traumatic event. The Modical Examinar must be notified at		Lorraine Griff			Sereni				0658
ָׁט ס	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or othar tra once.		20a. Method of Disposition  X Burial 2 Cremation 3 F	20	ob. Place of Dispo cemetery, cre	osition (Name of matory or other place d Veter	one 11/	Date 2	oc. Location - City o	
	it. Pag vrtment ortant: njury e		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licens</li></ul>				i			,215
Ö	Departing Department of the sany Irrespondent		14 1/25	-////	DAO VI	REHART-E	CHOLS F	UNERAL	HOME, PA	
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only of	lications that caused the ne cause on each line.	death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	STATIC	ADEN	10 CARCO	NUMA		5 months
	Examiner		Sequentially list conditions	bue to (or as a cor	isequence oi).					
	pe isit	ılner	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury	Due to (or as a cor	nsequence of):					
,	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence of):					
0070	eath certificate be executed attending physician and for usa as the burial-transit	cal		d						
) Y	certific ding p	hysiclan/Medl	IF FEMALE:	23c. If yes, outcome of pr	egnancy				23d. Date of de	elivery
YOU .	death e atten	iclan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _			Month	Day Year
5	d by th	Phys	9 ☐ Unknown  Part II. Other significant conditions co		t reculting in the	Inderlying cause grad	on in Part I	23e Did tob	acco use contribute	to the cause of death?
Č C	v requires that the de been signed by the should be detached	d by	LURUNARY ARTI			andenying cause giv	off fire gift.			Probably 4 Unknown
2	aw requir is been si 2 should	Completed	nin Bieties m	MELLITUS				24a. Was an	24b. Were a	autopsy findings available completion of cause of
ב ב	: The law cate has	Com	MINERTIEN	110~				perform 1 Yes 2	ed?   death?	s 2 No
VII	siclan certifi	o Be	25. Was case referred to medicat examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ☐ EB/Outpatie	ot 3 DOA Oth		th (Check only one	nce 6 Other (Sp	anifu)
5	*Attending Physician: The sr death. ector: After this certificate by the funaral director, pag	-	27. Manner of Death  1 Watural 5 Pending	28a. Date of Injury (Month, Day Yea	28b. Time o			28d. Describe how		<del>o</del> cny)
N S S S S S S S S S S S S S S S S S S S	I or Attendir after death. Director: Al I in by the fu	icatle	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home farm et	M 1 🗆	Yes 2□No	28f Location (Str	eet and Number or F	Jural Bouta Number
2	al or Attendes after death	Certification:	4 Homicide determined	building, etc. (St	pecify)	reet, ractory, office		City or Town,		iorar House Namber,
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical C	(Check only 2 Medical Exami	rsician: To the best of my	knowledge, deat mination and/or in	th occurred at the tin	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manner a te and place, and du	as stated. se to the cause(s)
	ro the within 2 ro the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	29	d. Date signed (Mon	nth, Day, Year)
			1 Am	•		Do	03838	88	11-8-2	400
5	R 1721	walkers of collections and an article of the collection of the col	30. Name and address of person who co	.D. 8926 W	(Item 23a) (Type, loodyar	d Rd. C	inton,M	ID 20735	,	
100	Sta			32. Redistrar's S						
	Registr	rar	NOATO	LUU4	JAT A	The state of the s				

			State of Mar	yland / Depa	artment of I	Health ar	nd Mental Hyg	_	27570
			For State Ragistrar	Cer	rtificate of	Death			
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Year	3. Time of Death
	/Medic	al	DOROTHY ELOISE HINMAN  4a. Fecility Name (If not institution, give street and number)	_	4b. City, Town,	or Location of I	November	9, 2004 4c. County of Dea	2:40 a <sup>M</sup>
1	Examin	er			Pocomol			Worceste	
	Funeral		Hartley Hall Nursing Home 5. Social Security Number   6. Sex   7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Birth		thplace (State or Foreign
	Director		213-01-7210	89 Yrs.	Months Days	Hours	Min. 8. Date of Birtl (Month, Day September	4,1915 Vir	ginia
	DG &		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	lanyla sho	ŏ	MD Worcester	Pocomoke					1⊠Yes 2□No
	28a-1	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	ountry?
	3a or	<u> </u>	1006 Market Street		21851			USA	
	death ms 2	Funerai	11. Marital Status 12. Was Decedent Ev Armed Forces?	ver in U.S. 13.		Hispanic Origin	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am	
ဖွ	after or ite	F	1 Never Married 2 Married 1 ☐ Yes 2 X No		1 □ Yes 2 🛭 No		deno riican, sic.,	Specify	
8	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medical Evertive or must be challied at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:					W	nite
7	n 72 I	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most o ad)	of working	16b. Kind of Business	rindustry
12	withi iene. r then	E O	Elementary/Secondary (0-12) College (1-4or 5+	Cleric		•		Food Serv	ice
ğ	il Hyg other	Be C	17. Father's Name (First, Middle, Last)			18. Mother's	s Name (First, Middle,	Maiden Sumame)	
Maryland 21215-0036	uld be Wenta Wenta Irked Itic e	To B	William Edward Hinman			Marg	aret Walla	ce Parks	
lan	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Meniat Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinating that be notified at any older.		19a. Informant's Name/Relationship (Type, Print)		-			r, City or Town, State,	
2`	ss 1 and 2 of Health a item 27 is other trac		Carol Lynne Ollendike (cousin)				Date	y, MD 2180	
Baltimore,	iges to the state of the state		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo			11		
Ħ	it. Partition of the property		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funerål Servige Licensee					Pocomoke C	ity, MD
Ba	Depa Depa Impo any i		Muchael ADour	1 1	03 Linde	en Ave.	Funeral H . Pocomoke	City, MD	21851
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	he death. Do not ent	er the mode of dy	ing, such as ca	ardiac or respiratory ar	rest,	Approximate Interval Between
1	Pnysician		Immediate Cause (Final disease or condition						Onset and Death
	/Medical Examiner		Due to (or as a	consequence of):			4		
	LXammer	<u>.</u>	Sequentially list conditions.  b. Sepons	consequence of):					
	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events						
Ć.	ie be executed /sician and e burial-transit	Examiner		consequence of):					
1760,		cal	d						
89	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be delached for use as it	Physician/Med	IF FEMALE:						
Вох	ath ce ttendi or use	lan/I	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	Ectopic pregnanc	су		23d. Date of de Month	livery Day Year
P.O.	the a	ysic	1 ☐ Yes 2 ☐ NO 4 ☐ Pregnant at ti 9 ☐ Unknown 9 ☐ Unknown	me of death 5	Other (specify) _				
	that the ded by detact	/ Ph	Part II. Dther significant conditions contributing to death but	not resulting in the u	nderlying cause g	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
rds	quires n sign ald be	d by	DYSPHAGIA				1 🗆 Y	es 2⊡No 3⊡P	robably 4 DUnknown
CO	s beel	Completed	MODERATE TO SEVERI	e Deme	NTIA		24a. Was		utopsy findings available completion of cause of
Re	The lav	mo					— autop perfor 1 ☐ Yes	med? _ death?	completion of cause of
ita		Bec	25. Was case referred to medical examiner?				f Death (Check only of		
× ×	S .S .D	ပ္	1 ☐ Yes 2 ☐ NO Hospital: 1 ☐ Inpatient	t 2 ER/Outpatier	" 3 DOA			ence 6 Other (Spe	city)
Division of Vital Records,	Attending Physician: If death. ector: After this certific by the funeral director.	lon:	27. Manner of Death 1 Matural 5 Pending (Month, Day	Year) 28b. Time of Injury	Wo	uryat ork? ]Yes 2.⊟No		ow injury occurred	
isi	or Attendate death Director:	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injur	y - At home, farm, str			_	treet and Number or R	ural Route Number.
DΪ	al or A after i Dire d in by	Certification:	4 Homicide determined building, etc.	(Specify)	,,,		City or Tow	n, State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical C	29a. Certifier (Check only one)  1	examination and/or in					
	To the within 2 To the complet	Me	29b. Signature and title of certifier	. (	_	se number	1	29d. Date signed (Mon	*
				R SAMAL 1		62172		11/9/201	74
1	1.3		30. Name and address of person who completed cause of deal of the SAMM (60)	04 MARKET	r St (	o to mo 11	u ling 1	40 21851	•
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar	's Signature	out				

			1 - State Registrar Co	partment of Health and Men ertificate of Death	Reg. N2 004 37571		
	Physici /Medio		1. Decedent's Name (First, Middle, Last) William Lee HARRIS		Date of Death Amonth Day Year Vember 11 200 4 07:50 M		
1	Examir	ier	4a. Facility Name (If not institution, give street and number) Washington County Hospital	4b. City, Town, or Location of Death Hagerstown	4c. County of Death		
	Funeral		Social Security Number     Sex     Sex     Age (In yrs. last birthda	1	Washington Date of Birth Month, Day, Year)  9. Birthplace (State or Foreign Country)		
	Director		213-24-8001 1 <sup>™</sup> 2□ F 76 Yrs.  Usual Residence of Decedent	Months Days Hours Min. Ju	Date of Birth Month, Day, Year)  1y 23, 1928  9. Birthplace (State or Foreign Country) Maryland		
	/land		10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits		
	e Maria-1 sh	ctor	Maryland Washington Funk	stown	1 ∑Yes 2 □ No		
	with th	Funeral Director	10e, Street and Number	10f. Zip Code 21734	10g. Citizen of What Country?		
	ns 23	erai	4 West Cemetery Street  11. Marital Status 12. Was Decedent Ever in U.S. 13	Yes or No- 14. Race - American Indian,			
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygene. Health and Mental Hygene. Item 27 is marked other than "natural", or items 23a or 23a-f show other traumatic event, the Madical Examinating rount be notified at	by	1 Never Married 2 AMarried 1 AYes 2 No	Yes or No- n, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White			
15-0	72 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi	cedent's Usual Occupation we kind of work done during most of working . DO NOT use retired)	16b. Kind of Business/Industry		
121	within ene. than '	ldmc	Elementary/Secondary (U-12)   College (1-4or 5+)	self-employed	home construction		
d 2	il Hygi other	BeC	17. Father's Name (First, Middle, Last)		st, Middle, Maiden Surname)		
ylar	2 should be filed vand Mental Hygie Is marked other t sumatic event, III	To B	William N. Harris	Lula Ann	Gibson		
Maryland	12 sho		. It	illing Address (Street and Number or Rural Ro			
	1 and Health tem 27 other tr			position (Name of ematory or other place)	x 457, Funkstown, Md. 21734  20c, Location - City or Town, State		
Baltimore,	0 0 = 5		TE Curial E Estoralitation 5 Entantoval Hotel State	own Crematory 11/12/			
alti	permit. Pag Department Important: I any injury o			the state of the s	ICH FUNERAL HOME		
8	80 E E 9			415 E.Wilson Blvd., Ha	gerstown, Md. 21740		
	Physician		20a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	nter the mode of dying, such as cardiac or res ninal Aortre Aneure	Interval Between		
h	/Medical Examiner		Due to (or as a consequence of):				
	B #	ner	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c				
8760,	ate be executed hysician and the burial-transit	ical E	Due to (or as a consequence or):				
Ö	ifficate g phys	ed	d.		- 1		
.O. Box	at the death certificate be executed by the attending phystician and tached for use as the burial-transit	Physician/M		Ectopic pregnancy	23d. Date of delivery  Month Day Year		
۵.	requires that the ieen signed by th hould be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?		
ords	w require been sig should b				1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown		
Vital Records,	law as b 2 si	ompleted			24a. Was an autopsy findings available prior to completion of cause of		
alF	pag ate	O	OF Western description	1	performed? death?  ☐ Yes 2☑ No 1 ☐ Yes 2 ☐ No		
5	Physiclan: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient	26. Place of Death Che	eck onli one 5 ☐ Residence 6 ☐ Other (Specify)		
n of	ding Ph	T:uc	27. Manner of Death 1 ✓ Natural 5 ☐ Pending (Month, Day Year) 1 ✓ Natural 5 ☐ Pending (Month, Day Year)	of 28c. Injury at 28d. I	Describe how injury occurred		
Sio	tor:	catle	2 Accident investigation	M 1 Yes 2 No			
Division	after deat after deat Director: I in by the	ertification;	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f. L	ocation (Street and Number or Rural Route Number, City or Town, State)		
	Hospita 4 hours Funeral ely fillec	dical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal can be compared to the basis of examination and/or and manner stated.	ith occurred at the time, date and place, and d nvestigation, in my opinion, death occurred at	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)		
			Allewost.	144471	Nov. 14 3004		
H	J4+1		30. Name in ddress of person who completed cause of death (Item 23a) (Type	1.1			
	Sta	te_	31. Date filed (Month 1984) Year 2014 32. Degistrar's Signature	pers Kd HTM.	Md. 21742		
	Registr		NUV 10 2004 Julian 15. 15	perles			

			State State Registrar AMEND#19aperFH11/12	e of Maryland		artment of rtificate o		_	0001	07570	
			Decedent's Name (First, Middle, Last)	./04/11/1/12		incate o	Dealii	2. Date of Dea	Reg. No. U	3. Time of Death	
	Physici		Robert W. Hall, Jr.					Month November	er 7, 2004	03:27 A.M	
	/Medi Examir		la. Facility Name (If not institution, give street an	<sup>id number)</sup> Eastb	ound	4b. City, Town	, or Location of		4c. County of De		
			Suitland Parkway & Nay			Temp	le Hills	5	Prince G	eorge's	
	be filed within 72 hours after deeth with the Maryland tal Hygiene.  Idea Hygiene.  Idea Hygiene and other than "natural", or itams 23a or 28a-f show pount of the Mudical Examiner must be notified at or		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Ye Months Day		Hrs. 8. Date of Birt Min. (Month, Da	r, Year)	irthplace (State or Foreign Country)	
		Director	579-96-2942 Table M 2L  Journal Residence of Decedent	32	Yrs.			Nov. 1	4, 1971 W	ash. D.C.	
			10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits	
			Maryland Prince George	es Temp	le Hi	11s				1X Yes 2 □ No	
			Oe. Street and Number			10f. Zip Code			10g. Citizen of What 0	country?	
Maryland 21215-0036			4722 23rd Parkway Apt	. #8		2074	8		United St	ates	
		by Funeral	1 Never Married 2XXMarried 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Decedent Ever in U.S. ed Forces? Yes 2 1 No s, Give or Dates:	l l	Vas Decedent of fYes, specify C		n? (Specify Yes or No- Puerto Rican, etc.)	Specific		
5-0	72 h	To Be Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of					if working	working 16b. Kind of Business/Industry		
121	vithin ne n		Elementary/Secondary (0-12) College (1-4or 5+) 12 Delivery Techni				ired)	)		T.d	
5	iled w Hygier Ther ti		17. Father's Name (First, Middle, Last)		Deliv	ery lec		s Name (First, Middle,	Linen		
ano	d be antal		Robert W. Hall, Sr.					a C. Powell	,		
ary.	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Italia		19a, Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or						r, City or Town, State.	Zip Code)	
	elth a	1	Patricia <del>Patrick</del> T. Lorick-Hall	./wife				pt. #8, Te			
ore,	of Hee		20a. Method of Disposition		ce of Dispo:	sition (Name of natory or other p	lace)	Date	20c. Location - City o	r Town, State	
Ĕ	Pages ment of l		1X☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State	-	Memoria	· 1	1/13,04	Suitland,	Maryland	
Baltimore,	permit. Pages 1 and 2 should bu Department of Heelih and Menta Important: if item 27 is marked any injury of other traumatic en once.		21. Signature of Funeral Service Licensee	san				McGuire Fu		ice 20012	
		ledical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  7400 Georgia Ave. N.W., Wash. D.C.  20012  Approximate interval Between								
68760,	Attending Physician: The law requires that the death certificate be executed reach.  reach.  actor: After this certificate has been signed by the attending physicien and upposition and property the funeral director, page 2 should be detached for use as the burial-transit are property.		cause. Enter Underlying Cause (Disease or injury	a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.							
			esulting in death) Last C. Du								
P.O. Box		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify)						23d. Date of de Month	livery Day Year	
Vital Records, P		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown		
Ö		Completed						24a. Was a	24a. Was an 24b. Were autopsy findings available		
Be		E O						— autops perforr	autopsy prior to completion of cause of death?		
		0	25. Was case referred to medical				26. Place of	Death (Check only on	2 No Yes	2 □ No	
of V		To B	examiner?								
			7. Manner of Death 28a. D	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?					28d. Describe how injury occurred		
50		cat	2 Accident investigation 3 Suicide 6 Could not be	ho 1-0-( 3.1)			M 1 ☐ Yes 2 ☐ No		DRIVER OF CAR, OVERTURNED		
É	or At after c Dirac in by	Certification:	4 Homicide determined 28e. F	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
_	Hospital 4 hours a Funeral I tely filled		29a. Certifier 1 ☐ Certifying Physician: To	edge death	occurred at the	EBSUITUAM PKWY PAYLORPD.PGC			stated		
	within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
		Me	29b. Signature and title of certifier			29c. License number OCME		N N	29d. Date signed (Month, Day, Year) November 7, 2004		
	3	-	Name and address of person who completed	cause of death (Item 2	3a) (Type. F	Print)					
	C	10	MARGARUM P. K	ORFC  12. Begistrar's Signatur	111	Penn S		Baltimore,	Maryland	21201	
	Sta Registr		NOV 1 0 2004	2. registral o signatur	19	sport	201				

_				artment of Health and Mental Hygiene of Death	573
	Physic	ian	1. Decedent's Name (First, Middle, Last)  Dhillip Cold showayab Hill	Month Day Year	Time of Death
-	/Medi Exami	cal	Phillip Goldsborough Hill  4a. Facility Name (If not institution, give street and number)	Month Nov. 6, 2004  4b. City, Town, or Location of Death  4c. County of Death	1:20pM
	Lxaiiii	iei	Mallard Bay Nursing Home	Cambridge Dorchester	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 195–05–7948 7rs.	Months Days Hours Min. (Month, Day, Year) Country	State or Foreign
	σ		Usual Residence of Decedent		IUG
_	tiled within 72 hours after death with the Maryland Hyglene tither than "natural", or Items 23a or 28a-f show ant. If a Mudical Examinat must be notified at	or	MD Dorchester Cambrid	100.111	side City Limits <b>1</b> Yes 2 ☐ No
3	r 28a-	irect	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?	
3	23a o 23a o ust be	rai D	503 Muir Street, Apt. 104	21613 USA	
0	er dez Items	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 1 2 9 2 No	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Ind Black, White, etc.	lian,
036	ours aff	byF	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1943-46	1 ☐ Yes 2 🛣 No Specify: Specify: Black	
21215-0036	"natur	Completed by Funeral Director	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation  kind of work done during most of working DO NOT use retired)  16b. Kind of Business/Industry	
212	d withir	omp	Elementary/Secondary (0-12)   College (1-4or 5+)	hine Operator Construction	
pu	be filed tal Hyg d othe	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)	
ryla	d Men marke	70		Mary Hill	
Baltimore, Maryland	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hyglene Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant. If a Modical Examinat must be notified at once.			ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	)
ore,	of Hes of Hes of itam or othe		1 K Buriol 2 Cromotion 2 Domourol from State Cemetery, cren	matory or other place)	ate
ti m	it, Pag rtment rtant: I		'4 □Donation 5 □Other (Specify)		
Ba	Depa Impo any ii		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21	6.20
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	ter the mode of dving, such as cardiac or respiratory arrest.  Approx	oximate val Between
	Physician	3	Immediate Cause (Final disease or condition resulting in death)	CA COMYODATHY WE	t and Death
	/Medical Examiner		Due to (oras) consequence of):		
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that mitiated events resulting in death) Last C.  Due to (or as a consequence of):		
8760,	The law requires that the death certificate be executed the bas been signed by the attending physician and page 2 should be detached for use as the burial-transit	icalE	d		
9	ertifica ling ph e as th		IF FEMALE:		
Вох	leath certif attending I for use as	Physician/Med		□Ectopic pregnancy 23d. Date of delivery □Other (specify) Month Day	Year
P.O.	at the de by the a tached	hysi	9 Unknown 9 Unknown		
	ires tha signed I I be det	þ	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.  23e. Did tobacco use contribute to the caus	
cor	w require been signatured should b	ietec	Tous Cancer Change Range	0 + 100	
of Vital Records,	sician: The law certificate has l irector, page 2 s	Completed	Bon D. Nostatik Hypertropus	1 1 Yes 20 No	n of cause of
Vita	iclan: certific ector,	Be	25. Was call referred to medical examina?	26. Place of Death (Check only one)	
of	y Phys	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	
ion	uttanding P death. ctor: After / the funer	atio	2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office  28f. Location (Street and Number or Aural Route City or Town, State)	Number,
_	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certifica completely filled in by the funeral director,		29a. Certifier Physician: To the best of my knowledge, death	n occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	To the Hawithin 24 To the Fu	Medical	one) and manner stated.	vestigation, in my opinion, death occurred at the time, date and place, and due to the ca	
	To Wit	~	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Ye	ear)
			20. Name and address of paragraphy who completed gauge of death (Item 22a) /Time I	Print) 11/9/04	
			31. Date filed (Month Dev. Year) a 2004 32. Floistrar's Signature	Box 833, Cambridge, MD 2161	3
	Sta Registr		31. Date filed (Month Oxy Year) 0 2004 32. Figistrar's Signature	porti	

## William Henry Hannah, Jr.  ## Control Proved Control Provided P			1 10430 1	State of Manyland				-	_	;•
1 Decoder Name   First Methods   200   201   2			1 _ State	State of Maryland	-					L 37571
State   Security Cases   Security Charge   Security Purpose   Security	To a second						<i></i>	2 Date of Dea	th	3 Time of Death
State   Security Cases   Security Charge   Security Purpose   Security			William Henry	Hannah, Jr.				Novembe	$e^{\text{Day}}$ 5, $20^{\text{Yea}}$	4 9:14 p <sup>M</sup>
Second Second Number   10 Second Second Number   10 Second Seco	K		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Deat			
28-42-7435							-A-			
Use State of County   County	CALL TO STATE OF THE STATE OF T		_					8. Date of Birth	9.1 1051 No	Sirthplace (State or Foreign Country)
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The property of the property o	nylan show		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
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The part of the pa	natica	lete	15. Decedent's Edui (Specify only highest grade	cation e completed)	16a. Deced	dent's Usual Occup kind of work done	during most of wo	rking	16b. Kind of Busine	ss/Industry
WILLIAM HENRY HANNAM, Clyon Four, State, 20 Code  Whyra J. Hannah Wife  105. Design of Parameters Named Relationship (Type, Prett)  Myra J. Hannah Wife  105. Design of Parameters Named Relationship (Type, Prett)  Myra J. Hannah Wife  105. Design of Parameters Named Relationship (Type, Prett)  Myra J. Hannah Wife  105. Design of Parameters Named Relationship (Type, Prett)  Myra J. Hannah Wife  105. Design of Parameters Named Relationship (Type, Prett)  Myra J. Hannah Wife  105. Design of Parameters Named Relationship (Type, Prett)  Myra J. Hannah Wife  105. Design of Parameters Named Relationship (Type, Prett)  Ariang Relationship (Type, Prett)  Myra J. Hannah Wife  105. Design of Parameters Named Relationship (Type, Prett)  Ariang Relationship (Type, Prett)  Myra J. Hannah Wife  105. Design of Parameters Named Relationship (Type, Prett)  Ariang Relationship (Type, Prett)  Ariang Relationship (Type, Prett)  Myra J. Hannah Wife  105. Design of Parameters Named Relationship (Type, Prett)  Ariang Relationship (Type, Pre	within then	dwo					<b>5</b> )		Jursina	Association
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Proyection Medical Examiner    Proyection Medical Examiner	13 6		23a. Part1. Enter the disease, or compli shock, or heart failure. List only on	cations that caused the death.	Do not ent	er the mode of dyir	ng, such as cardia	or respiratory arre	est,	Approximate Interval Between
Due to (or as a consequence of):  ###################################	Physician	0	Immediate Cause (Final disease or condition		RDIA	c ARX	244MAMI	A		Onset and Death
Due to (or as a consequence of):  ###################################			resulting in death)	Due to (or as a conseque	ence of):	2- C.				70(17100700
Due to (or as a consequence of):    Justing in death) Last	Examile		Sequentially list conditions,			AKT PA	TUKE			YEARS
Due to (or as a consequence of):    Justing in death) Last	nsit	nln.	cause. Enter Underlying Cause (Disease or injury		1					YELRS
Second   Part	b, execu in and ial-tra	Exar	that initiated events							/EARO
The state of the s		cal		J						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death   1   yes 2   No 3   Probably 4   Unkn   24a. Was an autopsy findings available   25   Was case referred to medical examiner   25   Was case referred to medical examiner   25   Was case referred to medical examiner   26   Place of Death   Check on one   27   Manpér of Death   1   yes 2   No   No   No   No   No   No   No	C <b>58</b> artifica ing ph	Med	IF FEMALE:							
The state of the s	MO)	lan/	23b. Was decedent pregnant	1 ☐ Live birth 2 ☐ Fetal d	leath 3		,			
1   Yes 2   No 3   Probably 4   Unknown   1   Yes 2   No 3   No Name   1   Yes 2   No 3   Probably 4   Unknown   1   Yes 2   No 1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1	be de ched the de	ysic	1 ☐ Yes 2 ☐ No		ith 5∟	Other (specify) _				
1   Yes 2   No 3   Probably 4   Unknown   1   Yes 2   No 3   No Name   1   Yes 2   No 3   Probably 4   Unknown   1   Yes 2   No 1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1   Yes 2   No 2   No Name   1	that	Y P	Part II. Other significant conditions con	tributing to death but not result	ting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
State	quire;							1 □ Ye	s 2 ☑No 3□	Probably 4 Unknown
State	BCO law re	plet							24b. Were	autopsy findings available
25. Was case referred to medical examiner?	The The page	l mo						perform	ned? death	?
The state of the s	/ITA	0	examiner?			15.		th Check on one	2	
1   Natural   2   Accident   3   Suicide   4   Homicide   4   Homicide   4   Homicide   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier (Check only one)   29m. Certifier   1   Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title-of certifier   29c. License number   29d. Date signed (Month, Day, Year)   30. Name and address of person who completed cause of death (Item 25c) (Hype, Print)   HECTOR (OLLI SDN, MD)   300   1   HDSP LTML   DRINE (LICENSE)   1   -9 - DH   1   -9	F y sign	11-1	TEL TES ZENO	1 □ Inpatient 2 ½ El		, JU DOX	4 🗀 Nursing A			pecify)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	On dling h. After fune	tlon	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	Injury			280. Describe no	w injury occurred	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	VISI Atten r deal ector by the	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At hom	ne, farm, stre					Rural Route Number,
29a. Certiffier (Check only one)  29a. Certiffier (Check only one)  29b. Signature and title of certifier (Check only one)  29b. Signature and title of certifier (Check only one)  29c. License number (Check only one)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 29a) (Type, Print)  30. Name and address of person who completed cause of death (Item 29a) (Type, Print)  30. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	tal or rs afte el Dir	Cert	4   HORICIDE	building, etc. (Specify)				City or Town	, State)	
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23c) (Hype, Print)  HECTOR COLLISON, MD 3001 HDSP (TRL  31. Date filed (Month, Day, Year)  32. Registrar's Signature	5 4 2 3		Check only 2 Medical Exemit	ier: On the basis of examinatio	ledge, death	occurred at the tin	ne, date and place	, and due to the ca	use(s) and manner	as stated.
30. Name and address of person who completed cause of death (Item 23a) (Hypo, Print)  HECTOR COLLISON, MD 3001 HDSP (TKL)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	thin 2 the 1	Med	G/16)	and manner stated.						
State 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature	5 7 8 7 8 7 8		+ Holle	Te Calles	NE	D. CIUGIIS	17/.			
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	( 1		30. Name and address of person who co	mpleted cause of death (Item 2	Sa) (TyDe		y ce	1	11-7-	07
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	B12:1		HECTOR COLLISON, A	ND 3001 H	tosfit		VE	CHEVERLY	MD &	10785
ACOUNTED MOVE OF THE STATE OF T	St Regist		31. Date filed (Month, Day, Year)		K A	Goods				

		1 - For State Registrar	State of Maryla	and / Depa		Health and	Mental Hyg	iene g. 2004	37575
Physici		Hegistrar     Decedent's Name (First, Middle, Last,     Donald Hugh James)					2. Date of Death		1 40 2 5 - 11
/Medic Examin		4a. Facility Name (If not institution, give				or Location of Deat		4c. County of De	ath
Funeral		Mallard Bay Care 5. Social Security Number 6. Sec		rs. last birthday)	Cambr	If Under 24 Hrs	8. Date of Birth	Dorche 9. B	ester inthplace (State or Foreign Country)
Director			M 2DF 75	Yrs.	Months Days	Hours Min.	May 30,	1929 Ma	aryland
faryland show ed at	or	10a. State 10b. County MD Dorches		City, Town or Lo					10d. Inside City Limits
r 28a-	Director	10e. Street and Number	ter	Cambr	10f. Zip Code		10	g. Citizen of What C	Country?
ath wit		520 Glenburn Ave			2161			U.S.A.	
be filed within 72 hours after death with the Maryland ital Hygiene.  dother than "nature!", or items 23a or 28a-1 show event, the Midical Examinar must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No		Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	
21213-UU36 of within 72 hours after gliene. er than "naturel", or if the Medical Examin.	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most of wo	rking	6b. Kind of Busines	
Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)		did not			none	<u> </u>
	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, N		
Maryland d 2 should be file th and Mental Hy ? Is marked oth traumatic event	으	Charles Albert 19a. Informant's Name/Relationship (7)		19b. Maili	ng Address (Street		ı Fountair ural Route Number,	City or Town, State,	Zip Code)
0 _		Audrey J. Willoug		702 'b. Place of Dispo	Travers 5	St. Cambr	idge,MD 2	1613 Oc. Location - City o	r Town State
0 90=7		1 ☐ Burial 2 Cremation 3 ☐ F  '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cre	matory or other pla	C0)	13/04	Salisbur	
Baltimore, permit. Pages I ar Department of Hea Important: If item: any injury or other once.		21. Signature of Funeral Service Licens	99	alisbur	V Cremato Name and Addre	on of English		eral Home	
n goesa		23a. Part1. Enter the disease, or compleshock or heart failure. List only o	lications that caused the d	leath Do not en	00 Locust				Approximate
Physician		Immediate Cause (Final				i	c or respiratory arre	51,	Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a cons	sequence of):	7	LONG			12 MOS
Examiner	er	Sequentially list conditions, if any, leading to immediate	b Due to (or as a cons	sequence of):		Α			
<b>6U,</b> be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	c	4)					
0 00 00	cai E)	issuing in county and	Due to (or as a cons	sequence oi):					
Certificate certificate adding phy use as the		IF FEMALE:						7	
the death certificate by the attending phy trached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnand Other (specify)	у		23d. Date of de Month	elivery Day Year
IS, F.	by Ph	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	inderlying cause gr	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
COTOS w require been sig							12 10	2 □ No 3 □ F	Probably 4 □Unknown
The lay	Completed						24a. Was an autopsy perform 1 \( \text{Yes} \) 2	prior to death?	autopsy findings available completion of cause of s
VITA sicien: certific rector,	o Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only one		
	-	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2  28a. Date of Injury (Month, Day Year	28b. Time o		ry at	28d. Describe ho	nce 6 Other (Sp. w injury occurred	ecity)
DIVISION of or Attending Patter death. Director: After in by the funer	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2 □ No			
DIVISIC To the Hospitel or Attend within 24 hours after death To the Funerel Director: , completely filled in by the i	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, sti ecify)	reet, factory, office		City or Town,	eet and Number or F State)	fural Houte Number,
To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier Check only one) 1 Certifying Phy	sicien: To the best of my iner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occi	e, and due to the ca urred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
To the within 24	Me	29b. Signature and title of certifier	$R_{n}$	_	29c. Licens			d. Date signed (Mon	
		> / ffeel	eler au	1	1)2	638	8 1	VOU 12 2	2004
		30. Name and oddress of person who co	mpleted cause of death (	Item 23a) (Type,	Print)	is blue	rlock.	Vov 12 2 Mcl 2/6	43
Sta Registr		31. Date filed (Month, Day, Year) NOV 15	32. Registar's Si 2004	ignature	hades	J 11-	., -, -,		

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar  1. Decedent's Name (First, Middle, Las.	State of Maryl	and / Depa	artment o	of Health and of Death	Mental Hy	gienę 004 Reg. No.	37576
	Physic /Medi Exami	cal	BERTRAM W. KAPLAN 4a. Facility Name (If not institution, give BEVERLY HEALTHCARE	street and number)		FREDEI		NOVEMBE ath	Day Year	1:00 P <sup>v</sup>
	Funeral Director		5. Sociat Security Number 6. Se 052-14-0439 15 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	M 2□F 83	Yrs. last birthday) Yrs. City, Town or Lo		ear If Under 24 H ays Hours Mi		9. B 1920 NEI	rthplace (State or Foreign Country) VORK
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If itam 27 is marked other than "natural", or items 23a or 28a-f ahow or other fraumatic avent, the Medical Examinar must be notified at	Funeral Director	MD MONTGOMER  10e. Street and Number  2618 HENDERSON AVE		HEATON	10f. Zip Co			10g. Citizen of What C	1 ☐ Yes 2 ☐ No country?
0030	hours after dea ural', or Items	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	t	Vas Decedent f Yes, specify	of Hispanic Origin?   Cuban, Mexican, Pue No <i>Specity:</i>		14. Race - Am Black, Wh	
a 21215-0036	filed within 72 I Hygiene. other than "nat	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	cation e completed)  Cotlege (1-4or 5+)  4	(Give	OO NOT use re	lone during most of westired)  CIAL OFFIC		U.S. GOVER	
Maryland	nd 2 should be tth and Mental 27 is marked o traumatic ave	To Be	HYMAN D. KAPLAN  19a. Informant's Name/Relationship (Ty LILLIAN ABRAMSON-	•			ANNA LI	PKIN Rural Route Number	r, City or Town, State,	
Dallillore,	permit. Pages 1 and Department of Health Important: If Itam 27 any injury or other tr		20a. Method of Disposition  1 Berial 2 Commation 3 F  4 Donation 5 Dother (Specify)  21. Signature if Fundral Servin License	lemoval from State	Place of Disposementery, crem IATI ONAL	sition (Name of latory or other CREMAT Name and Ac	TORY 11/	Date 12/2004 FFORDABLE	FREDERICK 20c. Location - City of FALLS CHUR FUNERAL S URCH, VIRG	CH, VA ERVICE
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or timediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	RAL equence of):	r the mode of			est,	Approximate Interval Between Onset and Death
,000	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiated events resulting in death) Last	Due to (or as a cons DEME Due to (or as a cons	equence of):	SLON.				
.0.	at the death certific by the attending p tached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3 🗆	Ectopic pregna Other (specify			23d. Date of dei Month	ivery Day Year
	iaw requires that as been signed t 2 should be deta	ompleted by P	Part II. Other significant conditions con	tributing to death but not ri	esulting in the un	derlying cause	given in Part I.	23e. Did tob		the cause of death?  obably 4 □Unknown  topsy findings available
	certificate hi	o Be C	25. Was case referred to medical examiner? 1 □ Yes 2 M No H	ospital: 1 □ Inpatient 2 [	☐ ER/Outpatient	2 DO A	_	autopsy perform 1 □ Yes 2 ath Check only one	prior to death?  No 1 Yes	2 No
	After	Certification; T	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Ir V M 1	njury at Vork? □ Yes 2 □ No	28d. Describe how	eet and Number or Ru	
	within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifying Phys	building, etc. (Specifician: To the best of my krer: On the basis of examinand manner stated.	nowledge death	occurred at the	e time, date and place y opinion, death occu	City or Town,	State)	
1	Mith Common	Σ	29b. Signature and the of certifier    UAQu-   30. Name and address of person who cor	nolated cause of death (the	m 22a) (Tree P	Do	ense number 00 47951	l'	d. Date signed (Month	004.
1	Stat Registra	te	SIBTE A- KAZMI, Y 31. Date filed (Month, Day, Year) NOV 1 9 2004	814 To	LL Hou	SE AU	FRE FRE	DERICK,	MD 2	701.

			For State Registrar	State o	f Marylan	nd / Depa <i>Cei</i>	artment <i>rtificate</i>	of He	ealth an Death	d Mental Hy	giene Reg. No	2004	3757	17
F	hysici		1. Decedent's Name (First, Middle, I ROLAND WESL		ΓS					2. Date of De Month	eath Da	y Year 2004	3. Time of Dea 3:00	ath P <sup>M</sup>
ŧ	/Medio Examin		4a. Facility Name (If not institution, g Talbot Hospic	ive street and nu	m <i>ber)</i>			own, or l	ocation of D	Nov.	40	County of Death	3.00	1
	uneral rector		219-03-3471	Sex 1☐XM 2☐F	7. Age (In yrs. 9 2	last birthday) Yrs.	If Under 1 Months	Year Days	Hours I	Hrs. 8. Date of Bi Min. (Month, Da Aug. 2	orth $(0, 1)$	9. Birth Cou Ma	place <i>(State or Fo</i> intry) ryland	reign
Maryland	f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Carc	line	10c. Cit	ty, Town or Lo	ecation	P	resto	on			10d. Inside City Li 1 ☐ Yes 2 🖁	
with the	a or 28a Lbe noti	i Direc	10e. Street and Number 6359 Harmony	Road			10f. Zip C		655	-		tizen of What Cou		
III C I C I S I S I S I S I S I S I S I	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. It a Medical Examinat must be notified at 2008.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Dec Armed Fo	edent Ever in U orces? 2 No ve No ates:		Was Decede If Yes, specif		panic Origin , Mexican, P Specify:	? (Specify Yes or No Puerto Rican, etc.)	0-	14. Race - Amer Black, White Specify: W		
within 72 horens	than "naturi he Medical I	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		1-4or 5+)	(Give	dent's Usual kind of work DO NOT use Carpe	done du retired)	ıring most ol	f working		Cind of Business/I	ŕ	
/ Idii   C	irked other	To Be Co	17. Father's Name (First, Middle, La Giles E. Lewi						18. Mother's	Name (First, Middle rtha Ure	, Maider	Sumame)		
ind 2 sho alth and I	27 Is mu er traume		19a. Informant's Name/Relationship Jane Clendanie		hter		-			ad, Pres	-		p Code) 1655	
Dallillore, Dermit. Pages 1 &	ınt: If item ıry or oth		20a. Method of Disposition 1   Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spe		_   6	Place of Dispo cemetery, crei Peter	natory or oth	ner place	em. 11	Date / 11/04		ocation - City or 1 enstow:		
permit. Departr	Importa any inju once.		21. Signature of Funeral Service Lie	ensee		22 F	rame and ramp	Address tom	Fune	ral Home	e, P	A urg. M	21632	
/Me	sician edical miner	16	23a. Part 1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. Due to	each line.	nuence of):	er the mode	of dying	, such as car	rdiac or respiratory a	arrest,		Approximate Interval Between Onset and Deat WCLK	h
The law requires that the death certificate be executed	physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	(or as a conseq									
the death certif	been signed by the attending pl should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	itcome of pregna birth 2  Feta nant at time of d	al death 3	Ectopic pre					23d. Date of delive Month	r <b>ery</b> Day Year	
uires that	signed b	by	Part II. Other significant condition  AS \$\overline{\partial} \overline{\partial} \ove	s contributing to a	leath but not res	sulting in the u	nderlying car	use giver	n in Part I.			/	the cause of death bably 4 □Unkn	
	ate has page 2	Completed	congestive her	ert fack	we							prior to co	opsy findings avail ompletion of cause 2 \(\text{\subset}\) No	able of
OI VIIAI Physician: T	his certifi Il director	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No			ER/Outpatier		Other	. 4 🗆 Nursi	Death (Check only ng Home 5 ☐ Res	idence	Hospi 6 Other (Spec	ce Øuse	
lor Attending P	or: After the funera	ertification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	tion	of Injury ath, Day Year)	28b. Time o Injury	f 28	lc. Injury Work?	at ? es 2 □ No					
DIVISION OF VICE TO the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Diractor: After this certific completely filled in by the funeral director.	Certific	4 Homicide determin	ed 286. Place build	e of Injury - At hi ling, etc. <i>(Specil</i>	(y) 				City or To	wn, State			
the Hosp in 24 hou	the Fune	edical		eminer: On the b			vestigation, i	in my opi	inion, death	place, and due to the occurred at the time,	, date and	d place, and due	to the cause(s)	
To	<b>10</b>	Σ.	29b. Signature and title of certifier  Mathur Fo	sike	M	0	29c.	License $55$	number 2 <b>2</b> 5-/	,	29d. Da	te signed (Month)	Day, Year)	
			30. Name and address of person with MATTHEW FISCH	no completed cau	se of death (Iter	n 23a) (Výpe,	Print) Su	te/	Éa	spon 1	UD	21601	/	
ti i	Sta Registi		31. Date filed (Month, Day, Year)	32.	Tegistrar's Signa	ature	land !	P						

A. Facility Name (If not institution, give street and number)  10327 Shingle Landing Rd.  4b. City, Town, or Location of Death  10327 Shingle Landing Rd.  5. Social Security Number  10327 Shingle Landing Rd.  6. Sex  1		1 - For State Registrer		Maryland / De	ertificate of			Reg. No 2	004	3757
Second Secretify Purpose   Colony of Death   Second Second	ysician			D			Month	Day		3. Time of Death
10327 Shingle Landing Rd.   Bishopville   Worcester   Shipper	Medical caminer				4b. City, Town,	or Location of Dea				9:33A
T1-34-8528	ummer	10327 Shingle	Landing Rd					We	orceste	r
Table State    Table   State   Table   State   Table   State   Table   State   Table   State   Table   State   Table   State   Table   State   Table   State   Table   State   Table   State   Table   State   Table	eral ctor	171-34-8528			Months Days		n. (Month, I			
23a. If yes, outcome of pregnancy that indiated executing in death) as consequence of):  25. Was case referred to medical years of the residence of the residen	a		ity	10c. City, Town o	Location				1	IOd. Inside City Limits
23a. Pirt. Enter the disease it completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximate interval Between Oysel and Death   Condition	ctor	MD Word	ester	Bishor	ville					1 ☐ Yes 2 🕱 No
Sa Pirtl. Enter to diselect complications that caused the death. Do not neter the mode of dying, such as cardiac or respiratory arrest, interval Between Cream Stock, or heart failure. Limited a support of the cause of the death of the cause of the ca	Dire		Landina Dal						of What Cour	ntry?
16. Decedent's Education   16. Decedent's Education   16. Decedent's Hartal Coccupation   16. Decedent Hartal Coccupation   16. Decedent Hartal Coccupation   16. Decedent Hartal Coccupation   16. Decedent Hartal Coccupation   16. Decedent Hartal Coccupation   16. Decedent Hartal Coccupation   16. Decedent Hartal Coccupation   16. Decedent Hartal Coccupation   16. Decedent Hartal Coccupation   16. Decedent Hartal Coccupation   16. Decedent Hartal Coccupation   16. Decedent Hartal Coccupation   16. Decedent Hartal Coccupation   16. Decedent Hartal Coccupation   16. Decedent Hartal Coccupation   16. Decedent Hartal Part Part Part Hartal Part Part Part Part Part Part Part Part	eral		12. Was Decede			Hispanic Origin?	Specify Yes or f		Race - Americ	can Indian,
Joseph Vickers  19a. Informant's Name (Pest, Modelle, Asst)  19b. Mailing Address (Street and Number or Rural Route). Mumber, City or Town, State, 2tp Code)  Sherri Brickey (daughter)  20a. Nethod of Deposition 1   Burni 2   Commission 3   Removal from State 4   Deposition 1   Detail 2   Commission 3   Removal from State 4   Deposition 1   Detail 2   Commission 3   Removal from State 4   Deposition 1   Detail 2   Commission 3   Removal from State 4   Deposition 1   Detail 2   Commission 3   Removal from State 4   Deposition 1   Detail 2   Commission 3   Removal from State 4   Deposition 1   Detail 2   Commission 3   Removal from State 4   Deposition 1   Detail 2   Commission 3   Removal from State 4   Deposition 1   Detail 2   Commission 3   Removal from State 4   Deposition 1   Detail 2   Commission 3   Removal from State 4   Deposition 1   Detail 2   Commission 3   Removal from State 4   Deposition 1   Detail 2   Detail 3   Detail 3   Detail 3   Detail 3   Detail 4   Detail	by Fun	1 Never Married 2 M	arried 1 Tes 2)	<b>©</b> No			irto Rican, etc.)			
18. Mother's Name (First, Models, Asset)   18. Mother's Name (First, Models,	eted	15. Deced (Specify only high	ent's Education hest grade completed)	16a. De	cedent's Usual Occu	pation during most of w	orking	16b. Kind	of Business/In	dustry
18. Mother's Name (First, Modile, Most)	mp		) College (1-4d	or 5+)		9 <i>a)</i>		11.6	C	
Joseph Vickers   Sa. Informants Name Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Robus Names, City or Town, Stale, Zip Code)	a)		e, Last)	A.C	countain	18. Mother's N	ame (First, Midd			nment
198. Informart's Nama-Relationship (Type. Print)   199. Malling Address (Streat and Number of Plural Notine Number, City or Town, State. 200. Location - City or Town, State. 200. Location - City or Town, State   200. Loc	To B	Joseph Vicker	^s			Carrie	Mae D	ukes		
20a. Method of Disposition    Summation					ailing Address (Stree	t and Number or F	Rural Route Num	ber, City or To	wn, State, Zip	Code)
Survail   Comment   Cape   Henlopen Crem, II-II-04   Frankford, DE			y (daughter			Rd. WI				own State
21. Signified of Funeral Services   Jennese   108 William St., Berlin, Md. 2 8    22. Name and Address of Facility The Burbage Funeral Home   108 William St., Berlin, Md. 2 8    23a. Phrt. Enter the disease it complications that caused the death. Do not enter the mode of dying, such as cardae or respiratory arrest, immediate course from the state of the course of the state of the course of the state of the course of the state of the course of the state of the course of the state of the course of the state of the course of the state of the course of the course of the state of the course of the cour		1 🗆 Burial 2 💢 Cremation		cemetery,	crematory or other pla	· 1				
### Part   Enter the disease of recomplications that caused the death   Do not enter the mode of dying, such as cardiac or respiratory arrest,   Approximate infriend leavement   Part   Enter the disease or condition   Due to (or as a consequence of):				Cape						
Part II. Cher er w disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onser and Death Interval Between Onser and Death Interval Between Onser and Death Interval Between Onser and Death Interval Between Onser and Death Interval Between Onser and Death Interval Between Onser and Death Interval Between Onser and Death Interval Between Onser and Death Interval Between Onser and Death Interval Between Onser a		V . V/	Vanderson N	100284	tos William	n St. F	ne buri Kerlin M	nage Fi	unerai	Home
Due to (or as a consequence of):    Control	al	Immediate Cause (Final disease or condition	a	tati ()				arrest,		Interval Between
25. Was case referred to medical examiner?  1	ical	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	с							
25. Was case referred to medical examiner?  1   Yes   2   No	nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐Live birth 4 ☐ Pregnan	n 2 ☐ Fetal death t at time of death		y		23d.		•
25. Was case referred to medical examiner?  1   Yes   2   No   No    27. Manner of Death   Check only one    28a. Date of Injury (Month, Day Year)  28b. Time of Injury   28c. Injury at Work?   28d. Describe how injury occurred    28c. Injury at Work?   28d. Describe how injury occurred    28d. Describe how	d by Pt	Part II. Other significant cond	Itions contributing to death	h but not resulting in th	e underlying cause gr	ven in Part I.			/	
25. Was case referred to medical examiner?  1   Yes   2   No	complete						aut per	opsy formed?	prior to cor death?	mpletion of cause of
27. Manner of Death 1 XNatural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? M 1 Yes 2 No 28d. Describe how injury occurred 3 Succident 3 Suicide 4 Homicide 4 Homicide 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 3 Succident 3 Suicide 4 Homicide 28d. Describe how injury occurred 28d. Describe how injury occurred 3 Succident 3 Suicide 4 Homicide 28d. Describe how injury occurred 3 Succident 3 Suicide 4 Homicide 28d. Describe how injury occurred 3 Succident 3 Suicide 4 Homicide 28d. Describe how injury occurred 3 Succident 3 Suicide 4 Homicide 28d. Describe how injury occurred 3 Suicide 4 Homicide 28d. Describe how injury occurred 4 Succident 5 Suicide 6 Succident 1 Suicide 1 Succident 28d. Describe how injury occurred 3 Succident 3 Suicide 6 Succident 1 Suicide 1 Succident 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. D	a	25. Was case referred to medi-					eath (Check only	one)		
2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one) 29b. Signature and title or certifier 29b. Signature and title or certifier 29c. License number 29d. Date signed (Month, Day, Year)		1 ☐ Yes 2 🙀 No 27. Manner of Death	1 □ Inpa		tient 3 DOA	4 LI Nursing				y)
29a. Certifier (Check only one)  29a. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)	ificatio	2 Accident inve-	stigation Id not be 28e. Place of	Injury - At home, farm	M 1	]Yes 2□No	28f. Location	(Street and N	umber or Rura	il Route Number,
29b. Signature and title of centres 29d. Date signed (Month, Day, Year)		29a. Certifier 1 ★ Certif	ying Physician: To the be	est of my knowledge, d	eath occurred at the t	ime, date and plac	ce, and due to th	e cause(s) and	d manner as st	ated.
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  11-10-04  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  10-10-04  11-10-04  11-10-04  11-10-04	edio	(Check only 2   Medic	at Examiner: On the basis	s of examination and/o			curred at the time			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ANN F. COURTH WWY 115 - (ALROLL ST. SALISBURY 111 2185)	2	29b. Signature and title of certi	S A	MAIN	29c. Licen		7C		-	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ANILLY F. CALAIL W. 114 = CAIROLL ST. SALISBURY IN 218 5)		CAST.		1000	U	400,	<b>/</b>	1/-	10-	07
	)	30. Name and address of person	MAL WW	or death (Item 23a) (Ty	APROLL	CT.	CALICK	NRV	111	2/801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U 0 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) .Month Year **Physician** 830 PM 2004 MARGARET LOUISE MAY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Boonsbor Washington 11 lemonal Hon ahrne Redi If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🔯 F 1921 MARYLAND Director 215-14-1390 83 JUNE Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County in than "naturel", or iteme 23a or 28e-f ehow the Wedical Examiner must be notified at 1 ☐ Yes 21 No Completed by Funeral Director **BOONSBORO** MARYLAND WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21713 8507 MAPLEVILLE ROAD U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 212 No If Yes, Give Year or Dates: Specify: Specify. 3 X Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 8 OWN HOME permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If item 27 is marked only injury or company. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EDWARD H. SMITH BEULAH CLINE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21713 5718 MT. CARMEL CHURCH ROAD, BOONSBORO, MARYLAND LARRY E. MAY/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 Donation 5 Other (Specify) 11/16/2004 BOONSBORO CEMETERY BOONSBORO, MARYLAND 21. Signature of Juneral Service Licensee 22. Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME Kelly A. Zimmerman Boonsboro, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List enty one cause on each line. 23a. Part 1 Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ertensine ZCI /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ate has been sign page 2 should be 1 Yes 2 No 3 Probably 4 ∑Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 25 No To the Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28c. Injury at Work? the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 2353 527 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Opal Court, Hagerstown, Maryland Khalid Waseem, M.D.31. Date filed (Month, Day 32. Régistrar's Signature Year 6 State horde Registrar

DHMH 17 Rev 1/2001

of gares

State of Maryland / Department of Health and Mental Hygiene

			State of Maryla		Certificate of I			g. No2 11 (	11. 37500
			Decedent's Name (First, Middle, Last)				2. Dete of Deeth Month		3. Time of Death
	Physici /Medio		RUTH ELIZABETH MOWEN				NOVEMBE		004 6:45 P.M.
	Examir	er	4a Facility Neme (If not institution, give street and number)		4	tb. City, Town, or Lo		4c. County o	
			WILLIAMSPORT NURSING HOME 5. Sociel Security Number   6. Sex   7. Age (In yrs	a local birds	dev) If Under 1 Year	WILLIAMS:			SHINGTON
	Funeral Director		214-09-0989 1 M 2 F 93		rs. Months Deys	Hours Min.	8. Date of Birth (Month, Day, OCT. 7,	<sup>Year)</sup> 1911	9. Birthplace (Stete or Foreign Country) PENNSYLVANIA
	pu *		Usuel Residence of Decedent           10a. State         10b. County         10c. C	ity. Town	or Location				10d. Inside City Limits
	f aho	5	MARYLAND WASHINGTON	.,,		LIAMSPORT			1⊠Yes 2□No
	28a-	5	10e. Street end Number		10f. Zip Code	THIPLOKT	10	g. Citizen of Wh	nat Country?
	3a o	<u>=</u>	154 NORTH ARTIZAN STREET			21795		U.S	.A.
	deat	Funeral Director	11. Maritel Status 12. Was Decedent Ever in Armed Forces?	U,S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spo	ecify Yes or No- Rican, etc.)		- American Indian, White, etc.
Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: If item 27 is marked other than *natural', or items 23a or 28a-f ahow important: If item 27 is marked other than *natural and anyl hiury or other traumatic event, the Medical Examinat must be notified at once.	þ	1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 □ Yes 2 ☑ No	Specify:		Specify:	WHITE
5-0	72 h	Be Completed	15. Decedent's Education (Specify only highest grade completed)	16a. i	Decedent's Usual Occupa Give kind of work done of life. DO NOT use retired	ation during most of work	ing 1	6b. Kind of Bus	iness/Industry
12	within	ם	Elementery/Secondary (0-12) College (1-4or 5+)		HOMEMAKER	")		OLINI	HOME
5	Hygid Hygid Sther	00	17. Father's Neme (First, Middle, Last)		TOPIETAKEK	18. Mother's Name	(First, Middle, M		
<u>la</u> n	lid be ked o	To B	LUTHER W. GARNS			LAVERSA I	E. COREY		
ary	s marke		19e. Informant's Name/Reletionship (Type, Print)	19b.	Mailing Address (Street	and Number or Rure	el Route Number,	City or Town, S	itate, Zip Code)
	and 2 ealth e n 27 is		HARRIET L. BOWMAN-CAPRIO/DAUGH			AD, HAGERS			21742
Baltimore,	Peges 1 nent of Haint: If Iten		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removal from State	Place of I cemetery	Disposition (Name of , cremetory or other place	e)	Date 2	0c. Location - C	ity or Town, State
Ē	. Ред tment tant:		4 □ Donation 5 □ Other (Specify) BC	ONSB	ORO CEMETER		8/04 E	OONSBOR	O, MARYLAND
Bai	permit Depar impor any In		21. Signature o Inneral S 💢 ELicensee		22. Name and Address  BAST FUNER	AT THOMES	7606 Old		
_	20200		Kelly A. Zimme				Boonsbor		
The second	Physician		36 art Erier the Isease, or computations that caused the dea shock, or need failure. List only the cause on each line.	ith. Do no	ot enter the mode of dyin	g, such es cardiac d	or respiratory erres	51,	Approximate Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition	TES	TINAL HE	MORRHAC	iE		INGERS
T	-	_	Due to	(or es a co	onsequence of):				
	ted nsit	nine	b. CASTRO IN			(GNANG)	<u> </u>		YEARS
<u>,</u>	tificata be executed og physician and as the burial-trensit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	or es e co	onsequence of):				
68760,	ysicia ysicia	cal	Ceuse (Disease or injury that initieted events	or as e cc	insequence of):				
89	ortifica ing ph a as th	_	resulting in death) Last						
P.O. Box	ath ce	lan	d				***************************************		1
o	ha de r the c	ysic	Part II. Other eignificant conditions contributing to death but not re	sulting in t	the underlying cause give	en in Part I.			ribute to the cause of death?
ري ص	s that t ined by e data	by Physiclan/M	Cerebro vascular disease		with mm	Hiple	1 Tyes	2 2 No 3	B Probably 4 Unknown
Records,	To the Hospital or Attending Physician: The law requires that the death cen within 24 hours defordeath within 24 hours defordeath. To the Funcal Director: After this certificate has been signed by the ettendin completaly filled in by the funerel director, page 2 should be datached for usa	Completed	Strökes				24a. Wes an perform		24b. Were autopsy findings available prior to completion of cause of death?
Re	he lav e has age 2	E C					1 You	278No	1 Yes 2 No
ta	an: T tificat tor, pa	BeC	25. Was case referred to medical			26. Place of Death			12103 222(10
2	yalcla is cer direc	ToB	examiner? 1 ☐ Yes 2⊠No Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outr	patient 3 DOA Other		me 5□ Residen		(Specify)
0	nerel	崩	27. Manner of Deeth 1 ☑Natural 5 ☐ Pending 28e. Date of Injury (Month, Dey Year)	28b. Tir	me of 28c. Injury		28d. Describe how		
Sio	endfr eath. or: Af the fu	catic	2 Accident investigation			Yes 2 □ No			
Division of Vital	or Att	edical Certification:	4 Homicide determined 28e. Place of Injury - At I building, etc. (Spec	iome, farr	m, street, factory, office		28f. Location (Stre City or Town,	et and Number State)	or Rural Route Number,
	potrai ours erail (	2	29a. Certifier 12 Certifying Physician: To the best of my kn	owledge	deeth occurred at the tim	ne, date and place, a	and due to the cau	ise(s) and manr	ner as stated
	Hoan 124 h	ğ	(Check only 2 Medical Examiner: On the basis of exeminend manner stated.	ation end/	or investigation, in my or	pinion, death occurre	ed at the time, dat	e and place, an	d due to the cause(s)
	Vithir To th comp	Me	29b. Signature and title of certifier		29c. License	number	290	d. Date signed (	Month, Day, Year)
			17 Chave M)		D33	700		Nor 1	4, 2004
	3H-3		30. Name and address of person who completed cause of death (Ite			200	21795		1
0	Sta	te	31. Dete filed (Month Dev Year) 32. Retristrer's Sign		ansport,	MD	01117		
	Registr		NUV 16 2004 Secur	19.	South				

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Year 1040 PM **Physician** Minnice Margaret Nevember 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Heime Nursing Picasant View Maune Mira Maryland 4-101 Ballimore Nations Pilce If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 21 F 52 Oct.27,1952 Director 218-62-7789 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ral', or itama 23a or 28a-f shov Examiner must be nutified at 1 ☐ Yes 2 No Directo Maryland Washington Williamsport 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21795 15534 Clear Spring Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ages 1 and 2 should be filed within 72 hours after on to of Health and Mental Hygiene.

1: If item 27 is marked other than "netural", or than or other traumatic access. Yes 2XXIII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify Specify þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates White Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Louise Oakley Weimaster 2 Earl Martin Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Minnich - Husband 15534 Clear Spring Road Williamsport, Maryland 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of P 1 Burial 2XX remation 3 Removal from State permit. Page Department Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Nov. 15, 2004 Smithsburg, Maryland 21. Signature of Funeral Service Osborne Funeral Home, P.A. 425 S. Conococheague St. Williamsport, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or is in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Broncho-pneumonia One Week. /Medical Due to (or as a consequence of) **Examiner** Acute Renal Failure Months S-quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Non Insulin De endant Diabetes Mellitus Yours, Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Hypertension 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2℃ No 24a. Was an Coronary Artey Disease certificate has b autopsy 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one. Hospital: 1 | Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the f 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2004. November D 30469. 15, who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person B Vellanki, MD; Chevrolet Drive, #Suite 100, Ellicott City, No 21042. 32. Pagistrar's Signature 31. Date filed (Month State 5 Registrar

			1 _ For	State of	Marylan	•	artment of F		and Mental Hy	1 2001	37582
			Registrar  1. Decedent's Name (First, Middle	. Last)		061	tincate of	Dealit	2. Date of De		3. Time of Death
	Physici		BRENDA JOCYE M						NOVEMB	ER 04, 200	ar
	/Medic Examin		4a. Facility Name (If not institution		oer)		4b. City, Town, o	r Location o		4c. County of D	
			SOUTHERN MARYL	AND HOSPIT	AL CEN	TER	CLI	NTON		PRINCE	GEORGES
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under :	Min. (Month, Da	th iy, Year) 9.	Birthplace (State or Foreign Country)
	Director		217 56 5392 Usual Residence of Decedent	1 101 424631		54 Yrs.			JAN. 1	5, 1950 T	VASHINGTON, DC
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Mary Fr 8h	ţō	MARYLAND PRINC	E GEORGES	HIL	LCREST	HEIGHTS				XiX Yes 2 □ No
	h the	lrec	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
	th wit	Funeral Director	2294 ANVIL LANE				20	748		UNITED	STATES
	r dea	ner	11. Marital Status	12. Was Deced	es?	.S. 13.	Was Decedent of H	lispanic Orig an, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - A Black, W	merican Indian, /hite, etc.
36	s afte	by Fi	1 Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 □ Yes 🏋 If Yes, Give Year or Date			1□ Yes 🏋 No	Specify:		Specify:	BLACK
21215-0036	72 hours after death with the Maryland natural, or items 23a or 28a-f show Iteal Evariaties must be coulded at	edt	15. Deceden			16a. Dece	dent's Usual Occup	ation		16b. Kind of Busine	ess/Industry
215	within 73 ene. than "n	plet	(Specify only highes Elementary/Secondary (0-12)	st grade completed) College (1-4	or 5+)	(Give	kind of work done DO NOT use retired	during most d)	of working		·
	filed within Hygiene. Ither than ant, the Me	Completed	12TH			ADMIN	ISTRATIV	E ASSI	STANT	GOVERNI	MENT
nd	bed as a second	Be	17. Father's Name (First, Middle,						r's Name (First, Middle	· ·	٠
Maryland	s 1 and 2 should f Heelth and Men item 27 is marke other traumatic	င္	NICK JAMES JORD  19a. Informant's Name/Relations			10h Mailie	an Address (Street		EPHINE REDM		a Zin Cadal
Ma	nd 2 solith an 27 is o		CLIFFORD JORDAN				ONARCH L			WN, MD 206	
	theel tem		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of matory or other plac	Ţ	Date	20c. Location - City	
E O			YXBurial 2 ☐ Cremation '4 ☐ Donation 5 ☐ Other (S		ate		LN CEMET		11/12/2004	BRENTWOOL	), MD
Baltimore,	permit. Page Department of Important: if any injury or once.		21. Signature of Fun-ral Services	Licensee	00				ERAL HOME O		
<u> </u>	8258		1.7	11/compt		- 4	308 SUIT	LAND I	ROAD SUIT	LAND, MD 2	20746
			23a. Part1. Enter the disease, or shock, of heart failure. List	complications that cau only one cause on eac	ised the deat th line.	h. Do not ent	er the mode of dyir	ng, such as	cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or indition resulting in death)	a H M	OXIC		in dame	je			
п	Examiner			Due to (or	as a conseq	uence of):					
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a conseq	uence of):					
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease of injury that initiated events	c							
90,	icate be executed physician and the burial-transit	i Ex	resulting in death) Last	Due to (or	as a conseq	uence of):					
8760,	physical phy	dicai		d							
Box 6	death certifica e attending ph d tor use as th	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna					23d. Date of	delivery
B	death a atter d tor u	iciar	in the past 12 months?	4□Pregnar	h 2□Feta nt at time of d		Ectopic pregnancy Other (specify)	/		Month	Day Year
P.0	t the by the tache	Physician/Med	9 Unknown	9□ Unknow	m						
	₽ B B	by P	Part II. Other significant condition	ons contributing to dea	th but not res	ulting in the u	nderlying cause giv	en in Part I.		340	to the cause of death?
ord	w requires been sign should be									Yes 2.175NNo 3.□	Probably 4 Unknown
Records,	aw as b	Completed							24a. Was	osy prior	autopsy findings available completion of cause of
alF	Th ate pag									rmed? death 2 No 1 □ Y	
Vital	Physician: rthis certifica ral director, p	Be c	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		FD(O-tti-	Oth		of Death (Check only or rsing Home 5 Resident		
of		n: To	27. Manner of Death	28a, Date of	Injury	28b. Time of		y at		now injury occurred	респуј
ion	Attending r death. sctor: Afte	atio	1 ANatural 5 Pendin 2 Accident investig	9	Day Year)	Injury		۲۲ Yes 2∐۱	No		
Division	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could determ	ikad 289. Place of	f Injury - At he , etc. <i>(Specif</i>	ome, farm, str	eet, factory, office		28f. Location (. City or Tox	Street and Number or vn, State)	Rural Route Number,
Ω	lospital o hours af uneral Di sly filled in			<u> </u>							<u>\</u>
		edical	29a. Certifier Check only one)	g Physician: To the b Examiner: On the bas and manne	is of examina	wledge, deat ition and/or in	h occurred at the tirvestigation, in my o	ne, date and pinion, deat	d place, and due to the th occurred at the time,	cause(s) and manner date and place, and c	as stated. due to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and the of certifie				29c. Licens	e number		29d. Date signed (Mo	onth, Day, Year)
)					> 1		D28	8639		11/8/0	4
)	(15)		30. Name and address of person	who completed cause	of death (Item						-
			JACQUES A. ZEP				070 OLD 1	LINE C	CENTRE #310	WALDORF,	MD 20602
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 2 2		gistrar's Signa	_	20				
		€ .		1							

			1 - For State Registrar		Maryland		artment rtificate			and M	F	eg. No.	004	3758	3
ı	Physici	an	Decedent's Name (First, Middle	e, Last)							<ol><li>Date of Dea Month</li></ol>	Day	Year	3. Time of Death	
	/Medic		George		Miller						lovembe		2004	7:20 A	1
	Examin	er	4a. Facility Name (If not institution	_			4b. City, To		Location o Park				ounty of Deat		
			Washington Adv 5. Social Security Number		. Age (In yrs. la	et hirthday)	If Under 1		If Under a		8 Date of Birth		ontgome		
	Funeral Director	ù.	578-22-1226	1 <u>M</u> M 2□F	80	Yrs.		Days	Hours	Min.	Month, Day	Year) 22	Reid	hplace (State or Foreig untry) sville N.C	n
	land W		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits	
	Mary -f sh	ō	MD D	- 01-			v 11							1 X Yes 2 □ No	>
	1 the	Funeral Director	MD Princ  10e. Street and Number	e George's	U	pper 1	Marlbo 10f. Zip C					0g. Citize	on of What Co	untry?	
	3a o	D E	13506 Messeng	ger Place				2077	/.			TT C	.A.		
	deati	ner	11. Marital Status	12. Was Deced	ent Ever in U.S	. 13. \				gin? (Spe	cify Yes or No- Rican, etc.)		. Race - Amei		
9	after or Ite	Fu	1 Never Married 2 Marr	Armed Forc ried 1 ₩Yes 2 If Yes, Give	! □ No		rres,specin 1 ∐ Yes 2[		Specify:	i, Puerto F	tican, etc.)		Black, White	e, etc.	
8	72 hours after death with the Maryland natural; or Items 23a or 28e-f show dical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Date	e <i>s</i> :		103 20	<b>25.110</b>	эрвену.			3	B1	ack	
21215-0036	72 h "natu	Completed	15. Deceden (Specify only higher	it's Education st grade completed)		16a. Deced (Give	dent's Usual kind of work DO NOT use	Occupat done du	ion Iring most	t of workin	g	16b. Kind	d of Business/l	industry	
12	within lene. then "	mp	Elementary/Secondary (0-12)	College (1-4	tor 5+)			retirea)							
	filled Hygie ther ant, II		17. Father's Name (First, Middle,	Last)		Accou	ntant		18 Mothe	r's Name	(First, Middle,		vate		
Maryland	d be notal	э Ве	George J. Mill									vialideri C	umamoj		
7	should nd Men s marke umatic	은	19a. Informant's Name/Relations			19b. Mailin	no Address (	Street ar			lalker Route Number	City or	Town State 7	in Code)	
Z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Jessye P. Mil											aryland 20	-
altimore,	is 1 and 2 of Health a item 27 is other trau		20a. Method of Disposition	LCI/ WIIE	20b. Pla	ice of Dispo	sition (Name	e of		Da	te	20c. Loca	ation - City or 1	Fown, State	L
Ë	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S		ate	-	-			11/11	/0/4 1	livor	M alch	aryland	
alti	permit. DepartmImporte any inju		21. Signature of Funeral Service	Licensee	, ica		. Name and				B.Jenki				
m	88 5 8		M. Richark	Som		7	474 La	ando	ver F		andover				
	/Medical Examiner	Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ab	r as a conseque	ence of):								Interval Between Onset and Death	
P.O. Box 68760,	that the death certificate be executed be by the attending physicien and detached for use as the buriat-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 Fetal on that time of dea	death 3 🗆	Ectopic preg					23	d. Date of delin	very Day Year	
	w requires that been signed to should be deta		Part II. Other significant condition	ons contributing to deal	th but not result	ting in the ur	nderlying cau	ise given صبہ جر ا	in Part I.		23e. Did tol	acco use	contribute to	the cause of death?	Ī
brd	equir sen si ould	ted	ESND, Du	E COLUMN	1 600	שותכב	-11/0	رح	R		1 🗆 Ye	s 2 🗆	No 3∏Pro	bably 4 Whiknown	
Records,	2 8 2	Completed by									24a. Was a autops perform	y ned?	death?	opsy findings available ompletion of cause of	)
Vital		C	25. Was case referred to medical	1					26 Place	of Death	1 ☐ Yes 2	No	1 🗆 Yes	2 No	-
	Physician: r this certifica ral director.	0 B	examiner? 1 □ Yes 2 □ No	Hospital:	patient 2 E	R/Outpatien	t 3 DOA	Other			e 5 Reside		Other (Speci	ify)	
Division of		atlon: T	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig			28b. Time of Injury		c. Injury a Work?		28	3d. Describe ho			-97	
Divis	or At	Certification:	3 Suicide 6 Could determ	ined 288. Place of	f Injury - At hom g, etc. <i>(Specify)</i>	ne, farm, stre	eet, factory, o	office		28	3f. Location (St City or Town		Vumber or Rur	al Route Number,	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifyin 2 Medical one)	ng Physician: To the be Examiner: On the base and manne	is of examination	tedge, death on and/or inv	occurred at restigation, in	the time n my opir	, date and nion, deat	f place, ar h occurred	nd due to the ca d at the time, d	iuse(s) ar ate and p	nd manner as s ace, and due t	stated. to the cause(s)	
	To t To tll	ž	29b. Signature and title of certifie	r			29c. l	License r	number		2	od. Date :	signed (Month,	Day, Year)	
1			162	- Ich	itoh	ND	6	001	50		1	1/2	5/04		
)	(10)	1	30. Name and address of person	who completed cause	of death (Item 2	23a) (Type, I	Print)			_		1	- 4.4.7		
_	10		UR. DEANNA	WHITE	76	00 (1	ARROL1	AV	$\epsilon$ .	TAK	OMA &	ARK	Md	20912	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 2 200	4 Aceta	gistrar's Signatu	horse						,			

		. For	State of Maryland	d / Depa	artment	of Health and	Mental Hyg	giene	0.1	
		1 - State Registrar		Cei	rtificate	of Death		leg. No.	U4	37584
Physic	ian	1. Decedent's Name (First, Middle, Las	MURCHI	500	1		2. Date of Dea Month	Day	Year	3. Time of Death
/Medi		VARELIA		00/			11		2004	5:30PM
Exami	ner	4a. Facility Name (If not institution, give			4b. City, To	own, or Location of Dea	th	4c. County	of Death	
		Washington Ad 5. Social Security Number 6. Se	ventist Hospit	al	If Under 1	Takoma Par	S. 8 Date of Birth	,	ontgon	
Funeral Director			□ M 21 48			Days Hours Min		', Year)		ce (State or Foreign
		Usual Residence of Decedent			L		pail. 22	, 1990	wası	. , DC
yland		10a. State 10b. County	10c. City	, Town or Lo	cation				100	d. Inside City Limits
Mai	ctor	Maryland Prince	George's		Gre	eenbelt				1 DXYes 2 □ No
th the	Director	10e. Street and Number			10f. Zip C	ode		10g. Citizen of	What Countr	y?
ING Z IZ I 3-UU30  be filed within 72 hours after death with the Maryland ttal Hyglene. Id other then "neturel", or Items 23a or 28e-1 show event, the Medical Exemples must be notified at		9909 Good Lu	ck Rd.			20706			ted St	ates
r deg	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decede	nt of Hispanic Origin? (3 y Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Rac Blac	e - America: ck, White, et	c.
s afte	by Fi	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give		1 □ Yes 2	No Specify:		Specify	Afri	
Fig. 1		15. Decedent's Ed	Year or Dates:	16a Dece	dent's Heual	Occupation		16b. Kind of B		ican
ING ZIZIO- be filed within 72 tal Hygiene. d other then "nel event, the Medic	Completed	(Specify only highest gra	de completed)	(Give	kind of work DO NOT use	Occupation done during most of wo retired)	orking	700. Killa of B	usinesanidu	stry
the iene	шо	Elementary/Secondary (0-12)	College (1-4or 5+) 2			lerk Typist			Privat	e
Hygi Hygi other	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle,			
should be of Mental marked imatic ev	To B	Lawrence	Murchison				Cathe	rine Ro	binsor	L
re, Maryland Z IZ IS-UUSO s 1 and 2 should be filed within 72 hours af Health and Mental Hygiene. Item 27 Is marked other then "neturel", or other treumatic event, the Medical Exern	-	19a. Informant's Name/Relationship (1	Type, Print)	19b. Mailir	ng Address (	Street and Number or R	lural Route Numbe	r, City or Town,	State, Zip C	ode)
Ma alth ar 27 is		Darcel Murchiso	n - Son	660	)3 Medv	wick Dr., H	yattsvil:	le, MD	20783	
Saltimore, permit. Pages 1 an Department of Heal Importent; If item 2 any injury or other once.		20a. Method of Disposition	04	ace of Dispo	sition (Name	of er place)	Date	20c. Location -	City or Tow	n, State
<b>Saltimore,</b> Jermit. Pages 1 at Department of Hea Importent; If item any injury or othe any injury or othe page.		1 Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Removal from State	•		al Cem. 11/	11/2004	Suit	land,	MD
<b>Baltim</b> permit. Pag Department almportent; I		21. Signature of Funeral Service Licen					Stewart 1	Funeral	Home	
n salis		John T.	Merous, III			l Benning R			DC 2	20019
		23a. Part 1. Enter the disease, or company shock, pr heart failure. List only	plications that caused the deeth	. Do not ent	er the mode	of dying, such as cardia	c or respiratory are	rest,	1	Approximate nterval Between
Physician	ŀ	Immediate cause (Final disease or condition		1		6			(	Onset and Death
/Medical		resulting in death)	a. Hypoxic	ience of):	,	/				
Examiner		Sequentially list conditions	b sudden	cerdi	e de	22/5				•
ъ .≡	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience of):	: 0	-4-				
/6U, le be executed ysician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· myoczsa	151	INTON	chen				
60, be ex sician a burial		1030 King in dod. 17 Edot	Due to/(or as a consequ	ience orj:						
	dicai		d							
Hecords, P.O. Box 68 The law requires that the death certifica the has been signed by the attending phoage 2 should be detached for use as the	by Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnal	201		-				
death cer e attending for use	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal	death 3	Ectopic prec				te of delivery inth D	ay Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	Jain 5	1 Other (Spec	y)				
that the	, Ph	Part II. Other significant conditions c	ontributing to death but not resu	ılting in the u	nderlying cau	ise given in Part I.	23e. Did to	bacco use cont	ribute to the	cause of death?
Hecords, The law requires t The law seen signe The bear signe The	d b						1 🗆 Y	es 2 🗆 No	3 Probab	oly 4 Donknown
w require	Completed						24a. Was a	n 24h	More autons	y findings available
He lav	E						autop	sy	prior to comp death?	oletion of cause of
		OF Mas ages referred to modical							1 Yes 2	□No
	Be C	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 1 Inpatient 2	ER/Outpatier		Other	ath (Check only or		(5	
OT Phy r this	. To	27. Manner of Death	28a. Date of Injury	28b. Time o		, Injury at	Home 5 Resid			
DIVISION OF  I or Attending Physafter death. Director: After this Lin by the funeral d	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐ No				
VISION OT VITA Attending Physicien: or death. ector: After this certific by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be	200. Place of injury - At no	me, farm, str	reet, factory,	office	28f. Location (S	treet and Numb	er or Rural I	Route Number,
afte safte	Sert	4  Homicide	building, etc. (Specify	')			City or Tow	n, Statej		
DIVISION OF  To the Hospitel or Attending Phys within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral di		29a. Certifier 1 Certifying Ph	ysician: To the best of my know	wledge, deat	h occurred at	the time, date and place	e, and due to the o	ause(s) and ma	nner as stat	ed.
he Ho n 24 he Fu sletel	edicai	one)	niner: On the basis of examinat and manner stated.	ion and/or in	vestigation, in	n my opinion, death occ	curred at the time, o	ate and place,	and due to t	ie cause(s)
To the within 2 To the complet	Ž	29b. Signature and title of certifier			29c.	License number	2	9d. Date signe	d (Month, Da	ay, Year)
Ti	1	byh	(9)			47655		Nove	mber 1	.0, 2004
R (4)		30. Name and address of person who	completed cause of death (Item	23а) (Туре,	Print)					
1			R. Kelley, M.D.		01 Map	le Ave. Ta	koma Par	k, MD	20912	
S Regis	tate trar	31. Date filed (Month, Day, Year)  NOV 1 2 2004	2. Registrar's Signal	ture	160					

	1 - State Registrar					artment o <i>rtificate</i> d				Reg. No.	001	+ 3758
ian	1. Decedent's Name (First, Mid								2. Date of Dea Month	ith Day	Yea	3. Time of Dea
cal	Lee Spear Mi			-61		T			Nov.	5, 2	004	5:42
ner	4a. Facility Name (If not institution  Chesapeake W	-					m, or Location				ounty of De	
	5. Social Security Number	6. Sex	1		s. last birthday)	If Under 1 Ye		r 24 Hrs.	8. Date of Birth	) De	orche	ester Birthplace (State or For
	212-16-1747	1 🗆 🛭	M 2 € F	84	Yrs.	Months Da	ays Hours	Min.	8. Date of Birth June 22	Year 92	20 M	ary Land
	Usual Residence of Decedent  10a. State 10b. Coun	tv		10c. C	ity, Town or Lo	ocation						10d Incide City I
ō		, heste	r			bridge						10d. Inside City Lin
Directo	10e. Street and Number					10f. Zip Coo	ie		1	I0g. Citizer	n of What	Country?
alD	113 Somerset	Avenu	e			2	21613			Ţ	USA	
Funeral	11. Marital Status	12	. Was Dece Armed For	dent Ever in I	U.S. 13.	Was Decedent If Yes, specify 0	of Hispanic C	rigin? (Spe	cify Yes or No- Rican, etc.)	14.	Race - Ar Black, Wi	merican Indian,
by Fu		1	1 ☐ Yes If Yes, Give Year or Da	9		1□Yes 2□				St		White
					16a. Dece	dent's Usual Oc	cunation					ss/Industry
plet	(Specify only high	est grade d	completed) College (1-	4or 5+)	(Give	kind of work do DO NOT use re	one during mo tired)	st of workin	g	TOD. KING	OI Busines	samuustiy
Completed	Elementary/Secondary (0-12)		College (1			Homem	naker			Own	n Hom	e
Be	17. Father's Name (First, Middle		D0014						(First, Middle, I	Maiden Su	<i>(m</i> ame)	
은			•					ly Br				
	19a. Informant's Name/Relation Rufus Thomas M			Son					idge, M		own, State 1613	, Zip Code)
	20a. Method of Disposition	TTT0,	OL•/ t		-	sition (Name of matory or other						or Town, State
	1 Burial 2 □ Cremation 14 □ Donation 5 □ Other		noval from S	state				11 /00				Market, MD
	21. Signature of Funeral Service		0	Las	22	2. Name and Ad	IELELY; Idress of Faci	II/U9	72004	Last	new	Market, MD
	Josles Die	201-	Degi	xwe	el 3	urran-E 08 High	Bromwel St.	l Fun Cambr	eral Ho idge, M	me, I	1613	
	23a. Rant. Enter the disease, shock, or heart failure. Lis	or complica st only one	tions that ca	used the dea	th. Do not ent	er the mode of	dying, such a	cardiac or	respiratory arre	est,		Approximate Interval Between
	Immediate Cause (Final disease or condition	a	Su	16	Arec	1. 1. 101	· 8 11	00.	101-1			Onset and Death
	resulting in death)	-			1	none	N M	emo	Tracq	Z.		
			Due to (d	r as a conse		none		emo	rracq			
<u>-</u>	Sequentially list conditions,	b		or as a conse	quence of):	7,01	× N	zmo	rraeg	e.		
miner	Sequentially list conditions, if any, leading to immediate cause. Entire Unsaryh in Cause (Disease or injury	<b>b</b>			quence of):		× 7	zmo	rrag			
Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. =	Due to (d	or as a conse	quence of):			2110	rrag			
cal	Sequentially list conditions, if any, leading to immediate cause. Entar Unjury, in Cause (Disease or injury that initiated events resulting in death) Last	b c	Due to (d	or as a conse	quence of):			2000	rrag			
cal	Sequentially list conditions, if any, leading to immediate cause. Either Unserflying Cause (Disease or injury that initiated events resulting in death) Last	d	Due to (c	or as a conse	quence of): quence of): quence of):			2000	rrag			
cal	resulting in death) Last	d	Due to (c	or as a consector as	quence of):  quence of):  quence of):  quence of):  ancy al death 3 [	]∈ctopic pregna	incy		rrag		. Date of do	•
cal	IF FEMALE: 23b. Was decedent pregnant	d	Due to (c	or as a consector as	quence of):  quence of):  quence of):  quence of):  ancy al death 3 [		incy	2000	rrag		. Date of do Month	elivery Day Year
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e Completed by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c d 23c	Due to (c	or as a consector as	quence of):  quence of):  quence of):  quence of):  ancy al death 3  death 5	Ectopic pregna Other (specify,	incy ) given in Part	1.	23e. Did tob	23d. pacco use of section 22/10/10/10/10/10/10/10/10/10/10/10/10/10/	Month  contribute  o 3 F	Day Year to the cause of death? Probably 4 Unkno
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<b>Physic</b>	ion	Decedent's Name (First, Middle	State of em 23a&27 p						2. Date of De Month	ath		3. Time o	of Death
/Medi		Dolores		Petrait	is				NOVEMB	ER 16.	Year 2004	3: 50	0a '
Exami	ner	4a. Facility Name (If not institution DOCTORS COMMUNI				City, Town, or	Location of	Death		4c. Coun	ty of Death		
Funeral		5. Social Security Number		L Age (In yrs. last		NHAM	If Under 24	4 Hrs.	8. Date of Birt	-	E GEO		
Director		213-40-5360	1 □ M 2 🕱 F	87	Yrs. Mon		Hours	Min.	(Month, Da Mar 31	y, Year) 1917	Сош	place (State of stry)	
3		Usual Residence of Decedent  10a, State 10b, County		100 City T									
media in the man in the manual, or items 23e or 28e-f show off it is marked other than "natural," or items 23e or 28e-f show other traumatic event, the Madical Examinat must be notified at	0		ce George's		own or Location College	Park					1	0d. Inside C	1
28a-	Director	10e. Street and Number				Zip Code				10g. Citizen of	(14/1-4-0		د ا
38 O		7307 Radcliffe	Drive		100	20740				rog. Citizeri oi	USA	itry ?	
ems;	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. Was De		spanic Origi	n? (Spec	ify Yes or No- ican, etc.)	- 14. Ra	ce - Americ		
Cillus I	by Fu	1 ☐ Never Married 2 ☐ Marri 3 ☒ Widowed 4 ☐ Divorced	ried 1 Tyes 2	™No		specily Cubai s 2⊠ No	Specify:	rueno n	ican, etc.)	Speci	ack, White, ifv: Wh	etc. ite	
Cal		15. Deceden	it's Education		6a. Decedent's U	Jsual Occupa	ation			16b. Kind of I		d	
raumatic event, the Medi	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed)  College (1-4		(Give kind of life. DO NO	work done d Tuse retired)	uring most o	of working	7	TOD. KING OF	ousiness/mc	uustry	
2	Con		3	51 517	Homema	ker				Own	Home		
949	Be	17. Father's Name (First, Middle, Walter Karro	-				18. Mother's	s Name		Maiden Suma	,		
matic	70	19a. Informant's Name/Relations						essi		vailabl	,		
trau		Karel C. Petra			9b. Mailing Addr								
		20a. Method of Disposition		20b. Place	7307 Ra	Name of		ve, Da	college	Park, 20c. Location			
ry or		1 ☑ Burial 2 ☐ Cremation  '4 ☐ Donation 5 ☐ Other (S			of Heav			11/2	1/200/		•		`
Important: If is any injury or once.		21. Signature of Funeral Service		0,	22. Name	and Address	s of Facility	Gas	ch's Fu	ineral	Home.	P.A.	,
E & 8		H Const	ance.	Jase						sville		20781	
edical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Hypert	sed the death. Death ine.  ensive a as a consequence.		node of dying					ase	Approximat Interval Bet Onset and I	e ween
edical miner parial transit	al Examiner	Immediate Cause (Final disease or condition	a. Hyperto Due to (or b. Due to (or c.	ensive a	arterios ce of):	node of dying					ase	Approximat Interval Bet Onset and I	e ween
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37587 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** NOV 2004 12:16 hirler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery

9. Bithplace (State or Foreign
Country) HOS Inder 1 Year If Under 24 Hrs. Adventist 7. Age (In yrs. last bir nday) If Unde 5. Social Security Number **Funeral** Year) 1 □ M 2 F Days Hours 68 Yrs. 46 257 Director Wash Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mactical Expension must be notified at Yes 2 □ No Director MD Montgomer Dilver 10e Street and Number 10g. Citizen of What Country? S 20906 3201 rinc Funerai 12. Was Decedent Ever in U.S. Arned Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes No þ Specify: 3 Widowed 4 □ Divorced ac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nt any injury or other traumatic event, the Maria once. Elementary/Secondary (0-12) College (1-4or 5+) Retai unknow 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marsha 55ac Inclina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 544 Melaway 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale MD hambers 21. Signature of Funeral Service Licenses Funeral Home 22. Name and Address of Facility Rhines WIGES n 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) transit The law requires that the death certificate be executed and Due to (or as a consequence of) physician a s the burial-t Division of Vital Records, P.O. Box 68760 Physician/Medicai use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth for in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) the a signed by cant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 1 Yes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only on Hospital: Other: 4 \sum Nursing Home 1 Tes 20 20 No 2 ER/Outpatient 3 DOA \* Ineatient 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manher of De th 28d. Describe how injury occurred Certification; After 1 Natural Injury 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of 29d. Date signed (Month, Day, Year, completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

Registrar

State

ehe

31. Date lilod (Month, Day, Year)

			State of Mary	land / Dep	artment of Heartificate of De	alth and Me	•	9	*
		- 11	Registrar  1. Decedent's Name (First, Middle, Last)	Ce	Tuncate of De		2. Date of Death	. No.	
	Physic		Mabel Virginia Pritchett	-			Month November	Day Y	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo		Movember	4c. County of	004 2:40 a M
			Mallard Bay Care Center		Cambr	ridge			chester
	Funeral		4 DA4 meter	yrs. last birthday)		Under 24 Hrs.	8. Date of Birth (Month, Day, Y		Birthplace (State or Foreign Country)
	Director		218-20-5623 1 M XXF 82 Usual Residence of Decedent	Yrs.	Days		Feb 10,		Maryland
	land ow			c. City, Town or Lo	ocation				10d. Inside City Limits
Q	the Maryland 28e-f show	tor	Maryland Dorchester	Camb	oridge				XX Yes 2 □ No
K		by Funeral Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of Wha	at Country?
5	death w	la l	331 Choptank Avenue		21613			US	
P	er de İtems	nue	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.1	Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Spec Mexican, Puerto A	ify Yes or No- lican, etc.)		American Indian, White, etc.
36	hours after turei', or ite	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give X		1 ☐ Yes 2X No S	Specify:		Specify:	White
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "neturel", or Items 23e or amportent: if Item 27 is marked other then "neturel", or Items 23e or amportent: if Item Madical Examiner must be ance.		15. Decedent's Education	16a. Dece	dent's Usual Occupatio	n	16	b. Kind of Busin	ness/Industry
21215	within 7 ene. then "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done duri DO NOT use retired)	ng most of working	9		iood industry
21	ed wi ygien ter th	Con	8	S	eamstress			Clothin	g Manufacturer
pu	be fill d oth even	Be	17. Father's Name (First, Middle, Last)		18	. Mother's Name (			
Zla	nould be d Mental narked o	2	William Knippel				ne Ritte		
Maryland	d2sthancthanc7isn		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and				
	Heal Heal tem 2		Robert Kuhn Nephew  20a. Method of Disposition 26	<ol><li>Place of Dispo</li></ol>	Choptank Aversition (Name of	venue Car			nd 21613 y or Town, State
Baltimore,	ages ant of it: if if		ND Burial 2 Cremation 3 Removal from State	cemetery, cren	matory or other place) ss Cemeter				
ij	permit. F Departme Importer any Injur		21. Signature of Funeral Service Licensee		2. Name and Address o		VU4 DE	ericori, i	Maryland
m	Depar Impor any ir	-	Bain K. Burk	丁	homas Fune 00 Locust S	cal Home	P.A.	Ma	3 24 64 2
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	er the mode of dying, s	uch as cardiac or	respiratory arrest,	, Maryıa	Approximate
	Physician		Immediate Cause (Final disease or condition	Va Q C La	ALLECA	Dis	ase_		Interval Between Onset and Death
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	ed sit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	isedneuce of):					
	and and II-tran	хап	that initiated events resulting in death) Last  C.  Due to (or as a con	sequence of):					
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687	ificate g phys as the		d.						
Вох	leath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pre					23d. Date of	delivery
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P.0	that the dead by the detached	hys	9 ☐ Unknown 9☐ Unknown						
Ś	es the igned be de	by	Part II. Other significant conditions contributing to death but not	_		Part I.	23e. Did tobaco	co use contribut	e to the cause of death?
ord	w requir been s should	ted	Congestive heart fail	ure, p	leu(al et	14 SION	1 🗆 Yes	2 No 3	Probably 4 Caknown
Records,	e law has b	Completed	Deep Vein Intombosi	5			24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
		Cor	U				performed	스 I deat/	n? (
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		Oth	Place of Death (	Check only one)		
of	Phys r this ral dir	.T	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatient 28b. Time of	t 3 DOA Other: 4	Nursing Home			Specify)
O	ding P th: After I funera	tion	Datural 5 Pending (Month, Day Yea. 2 Accident investigation	r) Injury	Work? M 1 ☐ Yes		d. Describe how in	njury occurred	
Division	Attendir death.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - A	At home, farm, stre			. Location (Street	and Number or	Rural Route Number,
ā	el or Att s after de of Direct od in by t	ert	4 Homicide building, etc. (Sp	ecify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, St	ate)	risia riogio riambor,
	To the Hospitel or Attending Physicien: within 24 hours atter death:  To the Funerel Director: After this certific completely filled in by the funeral director,		29a. Certifier  (Check only (C	knowledge, death	occurred at the time, d	ate and place, and	d due to the cause	(s) and manner	as stated.
	To the H within 24 To the F complete	ledical	one) and manner stated.	ination and/or invi	estigation, in my opinio	n, death occurred	at the time, date a	and place, and o	due to the cause(s)
	To To To Con	Σ	29b. Signature and title of certifier	20	29c. License nur	nber	29d. I	Date signed (Mo	onth, Day, Year)
•			for a fam		H004	4615		11-13	2-04
			30. Name and address of person who completed cause of death (	100	Print) Real	ble St	11-	(-0.)-	2 (1. )
	Sta	to.	31. Date filed (Month, Day, Year) 32. Registrar's Si	/ CC		NIE OF	Cogun	1000	e mo
	Registr		NOV 1 2 2004	gnature	bodi				

Decedent Name   First Motion, Last   Charles   Linden REYNARD, Sr.   2 Date of Death Movember   33, 2004   1412   41.00   1412   45.00   100   1412   45.00   1412   45.00   100   1412   45.00   1412		_1	For State Registrar	State of Man	land / Dep <i>Ce</i>	artment of <i>rtificate of</i>		_	giene Reg. N2 0 0	4 3758
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Fundamental Prince Georges Hospital   4- Out   Teacher   Charles			Charles Linden RE	YNARD, Sr.				Month Novemb	er 13. 2	
Special Security Numbers   Control   Page   Control   Page   Pa						4b. City, Town,	or Location of Dea			
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Temporary   Temp		5	, A					8. Date of Birt	h y, Year)	9. Birthplece (State or Fo
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17. Farmer's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Mackins Name)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Mackins Name)   18. Mother's Name (First, Middle, Mackins)   18. Mother's Name (First,	sho sum									
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17. Father's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Majdre Summer)   18. Mother's	al', or its	Dy ru		1 X Yes 2 □ No				to Rican, etc.)		
17. Falmer's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Majdles, Majdles)   18. Mother's Name (First, Middle, Majdles)   18. Mother's	n natural	pieted	(Specify only highest grad	cation e completed)	16a Dece	dent's Usual Occu kind of work done DO NOT use retin	pation during most of wo	orking	16b. Kind of Busi	ness/Industry
Salida A. Higgs   Salida A.	giene giene	E			past	eurizer			milk pı	rocessing
Salida A. Higgs   Salida A.	al Hy d other		7. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,		
And Method of Deposition    20 Method of Deposition   10 Method of Deposition   10 Method of Deposition   10 Method   10 Metho		0	Huston L. Reynard				Sallie	A. Higgs		
And Method of Deposition    20 Method of Deposition   10 Method of Deposition   10 Method of Deposition   10 Method   10 Metho	and land									
1 A Burnal 2   Orenandor 3 A Removal from State   Cedar Lawm Mem. Park   11/18/04   Hagerstown, Maryla: 4   Contains   School (Special Lawm Mem. Park   11/18/04   Hagerstown, Maryla: 4   Contains   School (Special Lawm Mem. Park   11/18/04   Hagerstown, Maryla: 21. Signature of Emeral Service Licigates   22. Signature of Emeral Service Licigates   23. Part 1. Emer the disease, or completations that caused the death. Do not enter the mode of dying, such as cardac or respiratory arrest.   Approximate Interval Between Interval B	2 章 2 元	-					n Blvd.,			
23a Part. Enter the disease, or configications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest, interval between the cause of each inc. A PRIORY ARREST Consideration and the consideration of the cause of each inc. A PRIORY ARREST Consideration of the cause of each inc. A PRIORY ARREST Consideration of the cause of each inc. A PRIORY ARREST Consideration of the cause of each inc. A PRIORY ARREST Consideration of the cause of each inc. A PRIORY ARREST Consideration of the cause of each inc. A PRIORY ARREST Consideration of the cause of each inc. A PRIORY ARREST Consideration of the cause of each inc. A PRIORY ARREST Consideration of the cause of each inc. A PRIORY ARREST Consideration of the cause of each inc. A PRIORY ARREST Consideration of the cause of each inc. A PRIORY ARREST Consideration of the cause of each inc. A PRIORY ARREST Consideration of the cause of each inc. A PRIORY ARREST Consideration of the cause of each inc. A PRIORY ARREST Consideration of the cause of each inc. A PRIORY ARREST Consideration of the cause of the cause of each inc. A PRIORY ARREST Consideration of the cause of the cause of each inc. A PRIORY ARREST Consideration of the cause of the cause of each inc. A PRIORY ARREST Consideration of the cause of the cause of each inc. A PRIOR ARREST Consideration of the cause of the cause of the cause of each inc. A PRIOR ARREST Consideration of the cause of the	or of to	2	1 XBurial 2 ☐ Cremation 3 ☐ R	lemoval from State	cemetery, crer	natory or other pla	I	Date	20c, Location - Ci	ty or Town, State
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23. Part Lefter the disease, or conficientish that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval between the mode of dying, such as cardiac or respiratory arrest, interval between the mode of dying, such as cardiac or respiratory arrest, interval between the mode of dying, such as cardiac or respiratory arrest, interval between the mode of dying, such as cardiac or respiratory arrest, interval between the mode of dying, such as cardiac or respiratory arrest, interval between the mode of dying, such as cardiac or respiratory arrest, interval between the mode of dying, such as cardiac or respiratory arrest, interval between the mode of dying, such as cardiac or respiratory arrest, interval between the mode of dying, such as cardiac or respiratory arrest, interval between the mode of dying, such as cardiac or respiratory arrest, interval between the mode of dying, such as cardiac or respiratory arrest, interval between the mode of dying, such as cardiac or respiratory arrest, interval between the mode of dying, such as cardiac or respiratory arrest, interval between the mode of dying, such as cardiac or respiratory arrest, interval between the mode of dying, such as cardiac or respiratory arrest, interval between the mode of dying, such as cardiac or respiratory arrest, interval between the mode of dying, such as cardiac or respiratory arrest, interval between the i	mpo mpo any ir		21. Signature of Euneral Service License	m -	/ /					
Interval Battery  Thysician immodate Cause (Final Immodate) cause (F		-	23a Barti Fater the disease or correli	1 Jesmese	4	15 E. Wi	lson Blv	d., Hagen	rstown, M	
FEMALE   23b. Was decedent pregnant in the past 12 months?   1   Yes   2   No   2   Horsing and the past 12 months?   1   Yes   2   No   3   Probably   4   Horsing a warning?   1   Yes   2   No   3   Probably   4   Horsing a warning?   1   Yes   2   No   3   Probably   4   Horsing a warning?   1   Yes   2   No   3   Probably   4   Horsing a warning?   1   Yes   2   No   3   Probably   4   Horsing a warning?   1   Yes   2   No   3   Probably   4   Horsing a warning?   1   Yes   2   No   3   Probably   4   Horsing a warning?   1   Yes   2   No   3   Probably   4   Horsing a warning?   1   Yes   2   No   3   Probably   4   Horsing a warning?   1   Yes   2   No   3   Probably   4   Horsing a warning?   1   Yes   2   No   3   Probably   4   Horsing a warning?   1   Yes   2   No   2   No   3   Probably   4   Horsing a warning?   1   Yes   2   No   3   Probably   4   Horsing a warning?   1   Yes   2   No   3   Probably   4   Horsing a warning?   1   Yes   2   No   2   No   3   Probably   4   Horsing a warning?   1   Yes   2   No   2   No   3   Probably   4   Horsing a warning?   1   Yes   2   No   2   No   3   Probably   4   Horsing a warning?   1   Yes   2   No   2	xaminer	Lyanninei	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events	Due to (or as a co	RES PIRA	JORY 1	FAILURE			
25. Was case referred to medical examiner?	by the attending phy ached for use as the hvsician/Medic		23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	1☐Live birth 2☐ 4☐Pregnant at time	Fetal death 3		у			
25. Was case referred to medical examiner?	n signed and be det	בי בי				nderlying cause gr	ven in Part I.			
25. Was case referred to medical examiner?	s bee							24a Wasa	n 24h Wai	re autoney findings avail
The stand of the control of the co								autops perform	ned? prio	r to completion of cause th?
The state of the s	centi irecto	ונ	examiner?	ospital:	arrifara	· Ot				
1x ) funealler MD D0058290 11/15/04	or this oral d	-	1 163 202 140	1   Inpatient		3 DOA	4   Nursing F			(Specify)
1x ) funeuller MD D0058290 11/15/04	ath. r: Afte e fune			(Month, Day Ye	ar) Injury	Wo	rk?	200. 2030/100 110	ow alluly occurred	
1x ) funeuller MD 0058290 11/15/04	after de		datamiaad	28e. Place of Injury - building, etc. (S	At home, farm, stre	eet, factory, office				or Rural Route Number,
1x ) funeuller MD 0058290 11/15/04	24 hours Funera Jetely fille		(Check only 2 Medical Examir	ter: On the basis of exa	y knowledge, death imination and/or inv	occurred at the ti estigation, in my	me, date and place opinion, death occu	, and due to the carred at the time, d	ause(s) and manne ate and place, and	er as stated. If due to the cause(s)
1x ) funealler MD D0058290 11/15/04	To th comp					29c. Licens	se number	2	9d. Date signed (N	Nonth, Day, Year)
	AX		· luce	lace	MM	Do	05829	0	11/151	104
	1	3	0. Name and address of person who co	mpleted cause of death	(Item 23a) (Type, I		- 0 - (			-
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		3	11. Date filed (Month, Day, Year)  NOV 1 6 20	32. Registrar's	signature					

			1 - For State Registrar	State of Ma		partmen e <i>rtificat</i>			d Mental H	/ 11	04	37590
		Ė	Decedent's Name (First, Middle, La	ast)		Grincal	e or De	zalii	2. Date of D	1109.140.	04	3. Time of Death
	Physic		Ronney Lee Renne	r.Sr.					Month	Day	Year	4:00 A M
	/Medi Examir		4a. Facility Name (If not institution, git			4b. City,	Town, or Lo	cation of D	Novemb Death	er 13, 2	004 of Death	14.00 K
			100 Eastview Dri	ve		Hag	erstov	٧n		Wash	ingto	on
	Funeral			1V7 M 2 0 E	(In yrs. last birthda	y) If Under Months	1 Year   If Days   I		Ain (Month C	irth	9. Birthp	place (State or Foreign
	Director		220-28-2791 Usual Residence of Decedent	A W ZUP	71 Yrs.				Sept.	26 <b>,1</b> 933	Mary	//ľand
	land ow		10a. State 10b. County		10c. City, Town or	Location					1	0d. Inside City Limits
	Many -fsh	ţō	Maryland Washing	iton	Hagerst	OWD						1 □Yes 2 No
	n the	rec	10e. Street and Number	11011	nager 51	10f. Zip	Code			10g. Citizen of V	What Cour	ntry?
	th wit	Funeral Director	100 Eastview Driv	e'e		2	1742			USA		
	r dea	Iner	11. Marital Status	12. Was Decedent E Armed Forces?		B. Was Deced	ent of Hispa	anic Origin	? (Specify Yes or Nuerto Rican, etc.)		e - Americ	
36	within 72 hours after death with the Maryland ene. then "naturel", or Items 23s or 28e-f show ite rediffed at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 □ N If Yes, Give	. 1953-	1□Yes		Specify:	aonto i nouni, otor,		∞ Whi	
21215-0036	hour ture	ed b	15. Decedent's E	Year or Dates:	1955	adantla Hava	10					
15	nin 72 n "na n "na	Completed	(Specify only highest gr	ade completed)	(Gi	edent's Usua e kind of wor DO NOT us	k done durir	n ng most of	working	16b. Kind of Bu	astir	ng Equip.
2	d with	mo	Elementary/Secondary (0-12)	College (1-4or 5-		etmeta	Layo	out		Manufa		•
	al Hy I othe	Be	17. Father's Name (First, Middle, Last	)			18.	. Mother's	Name (First, Middle			
<u>X</u>	should be filed wind Mental Hygiers smarked other ti	70	Willis Henry Ren	ne <b>r</b>			E	dith	Mae Rick	ard		
Maryland	2 shot and is m		19a. Informant's Name/Relationship (		1				r Rural Route Numb			Code)
	l and fealth im 27 her t		Kathryn B. Renner	r - Wife		Eastvi		ive	7			
Š	iges in of h		20a. Method of Disposition 1   ↑ Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dis cemetery, co		_	į.,	Date	20c. Location -	•	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28e-f show any injury or other treumetic event, It. Medical Examinar must be retified at once.		' 4 □Donation 5 □ Other (Special 21. Signature of Funeral Service Line		Greenla			1	-16-2004			,Maryland
Ba	Depa Impo any i		rang (		_	22. Nam <i>e</i> and	onoco	cheac	sborne Fi			°.A. MD 21795
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each line	the death. Do not e	nter the mode	of dying, su	uch as card	diac or respiratory a	rrest,		Approximate Interval Between
Z	Physician		Immediate Cause (Final disease or condition		Luna	Con	cer					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):		200				/5	6 months
	Examine	_	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):									
	ted nsit	nine	cause. Enter Underlying	Due to (or as a	consequence or):							
,	ficate be executed physician and is the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):							
98760	icate be physicia s the bur	edical		d								
_							5.5					
ROX	death certifi e attending id for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		□Ectopic pre	gnancy				of deliver	у
0.	0 0 0	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at ti 9□ Unknown		Other (spe				Mon	th (	Day Year
1	hat the od by detacl	F.	Part II. Other significant conditions of	contributing to death but	not reculting in the	undarkina oo		Dodl	an- Dida			
Vital Records,	law requires that the as been signed by th 2 should be detache	d by	, and the state of	onthibuting to dodin but	not resulting in the	unuenying ca	nze diven ni	raiti.		obacco use contri		scause of death?
ဂ္ဂ	w require been signature	Completed							-			
ě	0 5 0	dmo							24a. Was autor perfo	osy pr	rere autop: rior to com eath?	sy findings available pletion of cause of
ē	ician: Th certificate rector, pag	ပို	25. Was case referred to medical					Di	1 ☐ Yes	2 ☑ No 1	Yes 2	2□ No
	Physician: r this certific ral director,	O B	examiner?	Hospital:	t 2 ☐ ER/Outpatio	nt 3 004			Death (Check only only only only only only only only		s (Canaital	
פר	ig Phys ter this neral di	ı.	27. Manner of Death	28a. Date of Injury (Month, Day	The second second		c. Injury at Work?	- Addraing		now injury occurre		
<u> </u>	ttending Pr death. tor: After th the funeral	atic	1 Natural 5 Pending 2 Accident investigation	1	rour, injury	м	1 🗆 Yes	2 🗆 No				
UIVISION	or Att fter de pirect n by t	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, s (Specify)	reet, factory,	office		28f. Location (S City or Tox	Street and Number on, State)	r or Rural	Route Number,
⊐	pital of urs all	O		<u> </u>								
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exen	ysicien: To the best of niner: On the basis of e and manner state	ixamination and/or i	th occurred at nvestigation, i	t the time, da n my opinior	ate and pla n, death oc	ccurred at the time,	cause(s) and man date and place, ar	ner as stat nd due to t	ted. the cause(s)
	To t Withi To t	Ž	29b. Signature and title of certifier			29c.	License nun	mber		29d. Date signed	(Month, D.	ay, Year)
	1X		michael 9	nulou			04	166	7	11 -	15.	04
ئے	H-7x1		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type	Print)	ical	(un	NV: H	can h		MA
	Stat Registra		31. Date filed (Month, Day, Year) 5 2	004 32. Registrar	s Signature	berker			1/2	141/		1- (1) -
				100	- /							

			1 - For MEND#11perINF RegistrarMEND#17per1	11/17/04/BW NF11/17/04/E	Maryland / McCo MW,McCo		artment <i>rtificate</i>					Reg. No.	004	37	591
	Physicia /Medic		1. Decedent's Name (First, Middle, Jane D. Reicher	rt							2. Date of De Month Novemb	er 6,		3. Time	
	Examin	er	4a. Facility Name (If not institution, 3406 Thornapple 5. Social Security Number	St.	er) Age (In yrs. last)	birthday)	4b. City, T Chevy	7 Cha			8. Date of Bir	Mo	ntgome:	ry	or Foreian
	Funeral Director		579.20.3569 Usual Residence of Decedent	1□M 2□F X	82	Yrs.	Months	Days	Hours	Min.	(Month, Da Mar. 1	y, Year)	2 Wasi	nplace (State untry) 1., D.	C
	e Marylan 3a-f show illfad at	ctor	MD 10b. County MD Montgo	mery	10c. City, To										City Limits s 2 □ No
	with th	Dire	10e. Street and Number				10f. Zip (						en of What Co	untry?	
99	d within 72 hours after death with the Maryland jene rt than "natural", or tlems 23a or 28a-f show I're Modical Examination unt be notified at	/ Funeral Director	3406 Thornapple  11. Marital Status  → Never Married 2 Marrie	12. Was Decede Armed Force	s?		Was Decede If Yes, specif	ent of His fy Cuban	panic Orig , Mexican, Specify:	gin? (Spec , Puerto R	ify Yes or No ican, etc.)		4. Race - Ame Black, White Specify: Wh:	e, etc.	
21215-0036	in 72 hours n "natural", dedical Exe	Completed by	3 Widowed 4 Privorced  15. Decedent's (Specify only highest	Year or Date Education grade completed)	16	Sa. Dece	dent's Usual kind of work DO NOT use	Occupat	tion	of working	g		d of Business/		
1d 212	e filed within all Hygiene. other than "vant, It e Mas	O	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, L Del Vecch	College (1-46		Book	keepei		18. Mother	r's Name	(First, Middle,		rnment Gurname)	Contr	actor
ylar	Menta Menta arkad	To B	Samuel Dell Vecc	hio					Iris	Ker	nod1e				
, Maryland	es 1 and 2 should be filed of Health and Mental Hygis if tiem 27 is marked other ir other treumatic event, II		19a. Informant's Name/Relationshi Iris Reichert/Da		3	406	Thorna	app1		, Ch	evy Ch	-	Town, State, Z	ip Code) B15	
Baltimore,	permit. Pages 1 Department of Hi Important; if iter any injury or oth		20a. Method of Disposition  1 ☐ Burial		como	tery, crea omfo		he <i>r pl</i> ace	N		10,200	4 Ale	ation - City or i	a, Va.	
Balt	permit. Departi Import any inj once.		21. Signature of Funeral Service L	R. Ru	yy-	51	30 Wis	scon	sin A	ve.	N.W., 1	Washi	Sons ington,		20016
	Pnysician		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition		sed the death. D n line. tatic Lu			of dying	, such as o	cardiac or	respiratory a	rrest,		Approxima Interval Be Onset and 2 yea	etween I Death
	/Medical Examiner	L	resulting in death)  Sequentially list conditions,	, Adeno	as a consequence	a of	Lung							6 yea	ru.
8760,	cate be executed oblysician and the burial-transit	dicai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	as a consequence										
O. Box 68	at the death certificate by the attending phys tached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		1 2 ☐ Fetal dea t at time of death		∃Ectopic pre ∃ Other <i>(spe</i>					23	3d. Date of deli Month	very Day	Year
rds, P	es this	by	Part II. Other significant condition Chronic Renal I		h but not resulting	g in the u	nderlying car	use give	n in Part I.			obacco use Yes 2 🗆	e contribute to		death? ]Unknown
Vital Records,	The law ate has b page 2 sl	Completed								_	24a. Was autop perfo 1 Yes		death?	topsy findings ompletion of 2 \(\textstyle \text{No}\)	
Vita	Physician: 1 this certificaral director, p	Be	25. Was case referred to medical examiner?	Hospital:				Other			(Check only c				
of	Phys r this ral dii	Ilon: To	1 ☐ Yes 2文 No  27. Manner of Death  1文 Natural 5 ☐ Pending investige	28a. Date of I (Month,	atient 2 ER/ njury 28t Day Year)	Outpatier  Time of Injury		c. Injury Work	at	28	e 50 Resided. Described		Other (Speciocourred	ify)	
Division	spital or Attending ours after death. eral Director; After filled in by the fune	ertification;	2 Accident investigation of Could not determine the could not determine the could not determine the could not be could not determine the could not b	ot be 28e. Place of	Injury - At home, , etc. (Specify)	farm, sti					3f. Location (3 City or Tox		Number or Ru	ral Route Nui	mber,
	do 4 do 4 do 5 do 5 do 5 do 5 do 5 do 5	edical C		Physician: To the be xaminer: On the basi and manner	s of examination										(s)
)	To the land	Me	29b. Signature and title of certifier		MO			License	number				er 9,		
	130		30. Name and address of person w					un D	a D	2001277	i110	MD 2	.0852		
	Sta	te	G. Peter Pushkas 31. Date filed (Month, Day, Year)	32. <b>₽</b> eg	1510 O1d istrar's Signature					COCKV	1116,	Z	.0052		
	Registr		NOV 10	2004	was /	Ø	spa	Kr							

			For State Registrar	State of N	Maryland	d / Depa <i>Cer</i>	artment of F	lealth a <i>Death</i>	ınd Mer		jiene	004	37592
	Physici: /Medic		Decedent's Name (First, Middle, La		IMS					Date of Dea Month	Day	Year 1004	3. Time of Death 10:00P M
	Examin		4a. Facility Name (If not institution, given Charlotte Hall				4b. City, Town, o Charlott		f Death		4c. Cc	ounty of Death Mary	
Ī	Funeral Director		Social Security Number 6. 5		Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. Ma	Date of Birth (Month, Day	Year) 1912	9. Birth Cou Geo	place (State or Foreign Intry) Orgia
	Maryland febow	tor	Usual Residence of Decedent  10a. State 10b. County  MD St. Mary	10	,	Town or Lo							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the	Director	10e. Street and Number 29449 Charlott		Onar	10000	10f. Zip Code 20622			1	USA	n of What Cou	intry?
920	be filed within 72 hours after death with the Maryland nial Hygiene.  Indicate than "natural", or Items 23a or 28e-1 ehow event, Ire Mcdical Examiner must be multied at	by Funeral	11. Marital Status  11 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force: 1 TYes 2 If Yes, Give Year or Dates	s? □N₀1956	to '	Vas Decedent of H	ispanic Orig an, Mexican, Specify:	gin? (Specify , Puerto Rica	/ Yes or No- an, etc.)	14.	. Race - Amer Black, White pecify: B1a	, etc.
Maryland 21215-0036	within 72 ho ene. than "natur te Medical I	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4o	or 5+)	(Give life. L	lent's Usual Occup kind of work done DO NOT use retired Cal Speci	during most d)			16b. Kind	of Business/Ir	ndustry
and 2	d be filed within and Hygiene.	To Be Co	17. Father's Name (First, Middle, Last unknown	")		negr	car speci		r's Name (F	irst, Middle,			
	ges 1 and 2 should be it of Health and Mental if item 27 is marked o or other traumatic eve		19a. Informant's Name/Relationship Rosemary Mason/Guardi		ialist	19b. Mailin 6420 A	g Address (Street 111entown R	and Number Coad, CA	r or Rural Ro Imp Spr	oute Number	r, <i>City</i> or <i>Ti</i> D <b>2</b> 074	own, State, Zi	p Code)
Baltimore,	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1		Ce	metery, cren	sition (Name of natory or other place lat 1. Cem		Date 1/23/20			tion - City or T yer, VA	own, State
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Lice	Dold		41	Name and Addre	vania A	venue, S	Suitland	1, MD 2	Home,In 20746	с.
	Physician		23a. Paper. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	ed the death line.	04	er the mode of dyin	g, such as o	cardiac or re	spiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	ence of):							
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	as a consequ as a consequ								
.O. Box 68	death certifi e attending p d for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal at time of de	death 3	Ectopic pregnancy	,			230	d. Date of delive	rery Day Year
Records, P.	requires tha	by	Part II. Other significant conditions  Congestive	heart	Jai	lting in the u	nderlying cause giv	en in Part I.	_	1 🗆 Y	es 2 🗆 N	No 3 □ Pro	
	The law ate has b page 2 s	Completed	Dementia	brillani	on						med? No	24b. Were autoprior to condeath?	opsy findings available ompletion of cause of
f Vital	S S	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	itient 2 E	ER/Outpatien	t 3 DOA Oth	00 .		heck only on 5 ☐ Reside		Other (Speci	fy)
sion of	ding h. After funei		27. Manner of Death  1 Natural 5 Pending investigation	n	njury Day Year)	28b. Time of Injury	28c. Injun Wor M 1	yat k? Yes 2 □ N	No	. Describe ho			
Division	tel or Attenders after deatl	Certification:	3 Suicide 6 Could not to determined	building,	etc. (Specify,	)	eet, factory, office			City or Town	n, State)		al Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Exa	hysicien: To the be miner: On the basis and manner	of examinati	vledge, death ion and/or inv	vestigation, in my o	pinion, deat	d place, and h occurred a	at the time, d	ate and pla	ace, and due t	o the cause(s)
}	To the within 2 To the complet	×	29b. Signature and title of certifier	2	) 		29c. Licens		799		J J	signed (Month, $03/3$	900 Y
C	K (2)		30. Namo and address of person who dwelle Sell	mD 1	00 t	tospi	el Rel,	Pair	ice f	Vecle	ricl	(,m)	20678
	Sta Registr		31. Date filed (Month, Day, Year) <b>NOV 1 2 200</b>		strar's Signat	ure de	K)						

	1 - State of Management	aryland / Department of Health and Certificate of Death	Mental Hygiene
Physician /Medical Examiner	Decedent's Name (First, Middle, Last)     RAYMOND ELLSWOR      4a. Facility Name (If not institution, give street and number)     Consular Keginal Medic		2. Date of Death Month Day Year 11 04 2004 14' 15 M
Funeral Director	5. Social Security Number	le (In yrs. last birthday)  67 Yrs.  If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth 9. Birthplace (State or Foreign
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important of Health and Mental Hygiene. Important of Health 27 is marked other than "neturel", or Items 23a or 28e-1 ahow any injury or other traumatic event, the Medical Examination willied at once.  To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5) 12  17. Father's Name (First, Middle, Last)	If Yes, specify Cuban, Mexican, Puer 1956-60  If Yes 2 No Specify:  16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)  FIREFIGHTER  SHERWOOD  19b. Mailing Address (Street and Number or Ref.)	10d. Inside City Limits  1
Sy-3484  Dy,  executed In and in-transit  Examiner  Examiner	*4 Donation 5 Other (Specify)  21. Signature Funeral Service License  23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir Immediate Cause (Final disease or condition resulting in death)  Due to (or as	CREMATORY OF DELMARVA 11/ 22. Name and Address of Facility HASTINGS FUNERAL H	IOME, SELBYVILLE, DE. 19975
P.O. Box 6 hat the death certific doby the attending platached for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 Fetal death time of death 5 Other (specify)	23d. Date of delivery  Month Day Year  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Onknown
Taymond Sherwo Division of Vital Records, To the Hospital or Attending Physician: The taw requires t within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled in Certification; To Be Completed by	29a. Certifier  (Check only one)  29b. Signature and title of certifier  building, etc.  building, etc.  building, etc.  building, etc.  Certifying Physician: To the best of and manner sta	ont 2   ER/Outpatient 3   DOA	29d. Date signed (Month, Day, Year)

Raymond Sherwood

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Physician Howard Edward SMITH November 13, 2004 4:00 a.m /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 21510 Boonsboro Mountain Road Boonsboro Washington County If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Aug. 22, 1929 Birthplace (State or Foreign Country) **Funeral** Days Min DOM 20 F 75 Yrs 212-24-6226 Director Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 CXNo Maryland Washington Funeral Director Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 14324 Daley Road 21740 or items 23a U.S.A. filed within 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1⊠Yes 2□No W.W. II If Yes, Give W.W. II Year or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: white Specify: Completed by 3 Widowed 4 □ Divorced naturai 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene important: if item 27 ia marked other than any injury or other traumatic event. It is the Mean injury or other traumatic event. Elementary/Secondary (0-12) 0-10 College (1-4or 5+) truck drive black top paving 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Franklin Smith Emma Elizabeth Feigley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Lisa Golden - daughter 21510 Boonsboro Mountain Road, Boonsboro, MD 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nov. 17, 2004 Hagerstown, Maryland 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose-Hill Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Physician/Medical Examiner or Attending Physician: The law requires thet the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. ery Disease Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 3 Unknown ģ Delipidenia Completed 24a. Was an autopsy performed? 24b. Were autopsy findings completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 25 4No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this funerel 28e. Date of Injury (Month, Dey Year) 28b. Time of 27. Menner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred Director: After 1 Naturel 5 Pending 1 Yes 2 No investigetion 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide within 24 hours e To the Funeral D completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 11.15.04 ause of deeth (Item 23e) (Type, Print) LCT HAGERSTOWN SHA

\* State

Registrar

31. Date filed (Month, Day, Year) 5 2004 32. Regis

32. Registrer's Signature

Spelle

			1 - For State of Maryland / Dep	partment of Health and Mental Fertificate of Death	Hygiene 004	37595
	Physici		1. Decedent's Name (First, Middle, Last)	2. Date of Month	Death Day Year	3. Time of Death
	/Medic Examin		Elmer Ellsworth Speaker  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	ber 12 200 4c. County of Dea	
	CXAIIII	iei	14913 Clear Spring Road	Williamsport		ngton
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday			rthplace (State or Foreign country)
	Director		220-18-3367 XXM 2□F 80 Yrs.			lary land
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or U	ocation	•	10d. Inside City Limits
	f sho	0				1 Yes 2 No
	death with the Maryland ms 23a of 28a-f show rmst be notified at	Director	Maryland Washington Washington Washington	Villiamsport 10f. Zip Code	10g. Citizen of What C	
	3a ol	Ö	14913 Clear Spring Road	21795	US	٨
	death	Funeral		. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - Am	erican Indian,
õ	or ite		1 Never Married 2 Married 1 Yes 2 No	1 Yes No Specify:	Black, Whi	ite, etc.
2-003p	ural",	d by	3 Wildowed 4 Divorced Year or Dates:			White
다 스	within 72 hours after ene. then "natural", or ite te Wedical Examine	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business	s/Industry
7	withi Bne. than	m a	Elementary/Secondary (0-12) College (1-4or 5+)	Carrier	N-	
<u> </u>	e filed within al Hygiene. I othar than vant, I'e Ne	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd	dle, Maiden Sumame)	wspaper
lan	2 should be and Mental is marked o reumatic eve	To B	Resley Ellsworth Speaker	Mary Elizabe	eth William	S
ar	2 sholl and h		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ling Address (Street and Number or Rural Route Num		
Ξ.	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other than "netural", or items 23a or 28a-1 show other traumatic event, it a Medical Examinar must be notified at		Martha Speaker - Wife 149	13 Clear Spring Road Wil	lliamsport.M	aryland 21795
ore	of Hi if itar		20a Method of Disposition 120b. Place of Disp	position (Name of Date amatory or other place)	20c. Location - City or	r Town, State
	Pag tment tant:		'4 □Donation 5 □Other (Specify) / Cedar La	wn Mem. Park Nov.16,2004	4 Hagerstown	, Maryland
g	permit. Pages Department of Important: If it any injury or c		21. Signature of Juneral Service Living	22. Name and Address of Facility Sporne Funeral Home, P./	۸.	21795
	202.0		233 Sent Enter the disease or complications that caused the death. Do not or	25 S. Conococheague St.	Williamspor	t, Maryland
			Rent. Enter the disease, or complications that caused the death. Do not er shock, or hear failure. List only one cause on each line.  Immediate Cause (Final	A A A	/ arrest,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	range B-cell Lyn	nphoma	2 years.
	Examiner					0
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
	cuted	Examiner	Cause (Disease or injury that initiated events c.			
o o	be execu ician and burial-tra	I Ex	resulting in death) Last Due to (or as a consequence of):			
0	sate phys	dical	d			
×	ding se as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		22d Date of do	livene
	atter after of for u	ciar	in the past 12 months?	□Ectopic pregnancy □ Other (specify)	23d. Date of de Month	Day Year
	the cachec	hysi	1 Yes 2 No 9 Unknown 9 Unknown			
, T	w requires that the death certific been signed by the attending F should be detached for use as		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Die	d tobacco use contribute to	o the cause of death?
cords	aquire en sig ould b	edt	. Cerepral vascular 15	chemic disease , 10	⊒Yes 2⊅No 3⊟P	robably 4 Unknown
ວ	law re as be 2 sho	piet	· Caronary aftery	disease, 24a. We	as an 24b. Were at topsy prior to	utopsy findings available completion of cause of
ב	The ate h page	Completed by		pei 1 ☐ Yes	rformed? death?	2 No
N 1 2	cian: sertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only	y one)	
5	Physi this c al dir	10	1 ☐ Yes \$2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of		sidence 6 Other (Spe	cify)
5	ding h. After funer	tion	1 Matural 5 Pending (Month, Day Year) Injury	of 28c, Injury at 28d. Describ Work? M 1 ☐ Yes 2 ☐ No	e how injury occurred	
VISION	Attan deat ctor: y the	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st	treet, factory, office 28f. Location	(Street and Number or Ri	ural Route Number.
5	al or a after a l Dire	Certification;	4 ☐ Homicide determined building, etc. (Specify)	City or T	Town, State)	
	To the Hospital or Attanding Physician: The law requires that the death certify thin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending from the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only    Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, and due to the	ne cause(s) and manner as	s stated.
	the H iin 24 the Fi	Medical	one) and manner stated.			
	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mont.	h, Day, Year)
	. 6		Mud Marrido	~ D46413	11/15	104
21	1		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	Haras	
	Sta	te.	31. Date filed (Month, Day, Ygar) 32. Registrar's Signature	130 OPITE (1)	116 ger	stown, MI
	Registr		NOV 15 2004 Been B. A.	sexes	V	211407

				ertment of Health and Mertificate of Death	ental Hygien Reg. N	ZIIII 37500
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Ching Jui Shih			3. Time of Death 8:30 PM
	Examir	ner	4a. Facility Name (If not institution, give street and number) National Lutheran Home	4b. City, Town, or Location of Death Rockville	1	c. County of Death Iontgomery
	Funeral Director		5. Social Security Number 6.1 $3-46-9232$ 6. Sex 7. Age (In yrs. last birthday 88 Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Year Mar. 13, 1	9. Birthplace (State or Foreign Country) China
	Maryland of show	tor	10a. State 10b. County 10c. City, Town or L	cocation Rockville		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	3a or 28e	al Director	10e. Street and Number 9701-Veirs Dr.	10f. Zip Code 2 0 8 5 0	10g. C	Citizen of What Country?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28e-1 show any injury or other traumatic event, it e Modical Exercities (stat be maiffed at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Chinese
Maryland 21215-0036	I within 72 ho iene. r than "netur It e Medical I	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired) Homemaker	g	Kind of Business/Industry  At Home
land 2	uld be fited Mental Hygid irked other itic event, II	To Be C	17. Father's Name (First, Middle, Last) Ching Chu Juo		(First, Middle, Maide	n Sumame)
	and 2 should ealth and Men n 27 Is marke ler traumatic	1 1		ing Address (Street and Number or Rural Monroe Street, Ro		
altimore,	Pages 1 ment of He ent: If iten ury or oth		*4 Donation 5 Other (Specify)	ematory or other place) Litan Crematory-	11/11/04	Location · City or Town, State -Alexandria, Va.
Balt	permit. Departr Importe any inju		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Hysong Co., In 6510-16th St	nc. NW.Was	hDC
	physician and water icase be executed with the physician and street is the burial-transit	Il Examiner	23a. Part1. Enter the disease, of complications that caused the deeth. Do not an shock, or heart failure. List only one dause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	org faile	respiratory arrest, encia re Lement	I week
.O. Box 68760,	Attending Physician: The law requires that the death certificate be execut rebath.  cloath.  sctor: Atter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial trans	by Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	quires that in signed t uld be det		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.		use contribute to the cause of death?
al Records,	ician: The law requir certificate has been si rector, page 2 should I	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1   Yes 2   No
f Vital	Physician this certif al directo	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2☐ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death ont 3 □ DOA Other: 4 □ Nursing Hom		6 □Other (Specify)
Division of	utending Ph death. ctor: After th y the funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)		3d. Describe how inju	
Divis	afte Dir	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28	Bf. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, deat 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	d at the time, date an	d place, and due to the cause(s)
	To Will	2	29b. Signature and title of certifier will could be colded to the could be colded to the could be colded to the could be colded to the could be colded to th	29c. License number 021726	29d. Da	wember 11,2004
R	) I		30. Name and address of person who completed cause of death (Item 23a) (Type, Dr.Charles W. Karesh- 9701-V		le,Md.20	850
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 1 2 2004  32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1, NOV EMBER **Physician** Ž004 PRISCILLA SAYEH 5:34 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11415 EMPIRE LANE ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Sept. 21 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) 1 1933 **Funeral** Months Days Hours 1 ☐ M 2 🖺 F 71 Yrs. Liberia 213-35-0059 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 1 ☐XYes 2 ☐ No Director Rockville Montgomery Md. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20852 11415 Empire Lane Liberia Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: Black 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th Domestic Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Lucy Forkay ٩ Stephen Togba 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoinette M. Sayeh / Daughter | 11415 Empire Lane Rockville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition o = 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 6 permit. Page Department of Important: If any injury or Souls Cemetery 11-13-04 \* 4 ☐ Donation 5 ☐ Other (Specify) Germantown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 20002 23a. Part1. Enter the disease, or camplications that caused the death. If not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** EREBROVASCULAR ACCIDENT /Medical Due to (or as a consequence of): Examiner ARDIOMYOPATH SCHEMIC S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the should be detached signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 certificate 1 ☐ Yes 2 ☑ No or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Hospital: 1X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medicai Certification: After 1 Natural
2 Accident 5 Pending s after death. М 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Hospital 🔁 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M. D. D-27660 10/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PIKE ROCKVILLE , MD 20852 11/19 N.D. ROCKVILLE GOSWAMI ALPANA 31. Date filed (Month, Day, Year) . Registrar's Signature State NOV 1 2 2004 Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 2000

37598

	•							Cer	tificate oi	f Death		Reg. No.	0 0 9	01030
			1. Decedent's Name (First, Mi	ddle, Lest)							2. Date of E	Death		3. Time of Death
	Physic /Medi		Bernice	Virg	ginia		S	Sowe	rs		Novemb	er 7, 2	004	7:20 AM
)	Exami		4a. Facility Name (If not institu	tion, give stre	et and nun	nber)				4b. City, Town, or			ty of Death	7.20 1111
			Waldorf Heal	th Care	e					Waldorf		Cha	rles	
	Funeral		5. Social Security Number	6. Sex		7. Age (In	yrs. last birt	thday)	If Under 1 Yea	r If Under 24 Hrs				lace (State or Foreign
	Director		232-03-2203 Usual Residence of Decedent	1□ M	2 <b>⊠</b> F		96	Yrs.	Months Days	s Hours Min	March	$29^{\text{Year}}, 190$	8 Mar	elace <i>(State or Foreign</i> http) yIand
	and		10a. State 10b. Cou	ntv		10c	City, Town	or Loc	ation				1	0d. Inside City Limits
	fanyt sho	ठ					•						[ ]	1 ☐ Yes 2X No
	he N	Director	Maryland   Char	Les		W	aldor	I	T			1		
	with the Maryland a or 28e-f show be notified at	ä	10e. Street and Number						10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	ath w	ra	4140 01d Was						2060			U.S	.A.	
Maryland 21215-0020	72 hours after death with the Maryland neture!', or items 23a or 28e1 show dical Examiner must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ N 3 ☑ Widowed 4 ☐ Divord	arried	Was Dece Armed For 1 ☐ Yes If Yes, Give Year or Da	9	n U,S.	1	as Decedent of Yes, specify Cul ☐ Yes 2 No	Hispanic Origin? (5 ban, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	Spec	ace - Americ ack, White, ify: White	etc.
9	2 ho	Completed	15. Deced	ent's Education	on		16a.	Decede	nt's Usual Occu	pation		16b. Kind of		
215	⊆ =	ple	(Specify only hig Elementary/Secondary (0-12	- F		Aor E ()	_	(Give k	ind of work done O NOT use retin	ipation e during most of wo ed)	rking			,
21,	within jene.	E	12	'   '	College (1-	-40r 5+)			nemaker			Own H	ome	
D	be filed withintal Hygiene. d other then	Bec	17. Father's Name (First, Midd	e, Last)						18. Mother's Na	me (First, Middle	1		
an	d be ental red c	a o	Joseph Dean									,		
<u></u>	s 1 and 2 should be if Health and Mental Item 27 is marked i other traumatic ev	၉	19a. Informant's Name/Relation	nehin /Tuna	Drint)		10h	Mailing	Address (Ctree	Mae Sey		O't T		
Ma	d2s than 7 is i													
e,	Healt m 2	- 1	Harry Jack Solution 20a. Method of Disposition	owers (	(SOII)	001				y Dr., So				
Baltimore,	permit. Pages 1 and 2 Depertment of Health a Important: If Item 27 is any Injury or other trai		1 X Burial 2 ☐ Crematio	n 3 🗆 Remo	oval from S	itate	cemeten	y, crema	tion (Name of atory or other pla	ace)	Date	20c. Location	- City or To	wn, State
Ë	ant:		4 ☐ Donation 5 ☐ Other	(Specify)			Rose	Hil	1 Cemet	ery 1	.1/10/04	Thoma	s, WV	
ä	port port y inj		21. Signature of Funeral Servi	e Licensee	)			22. IJ	Name and Addr	ess of Facility				
<b>@</b>	8 9 E 9 8		Lonnin	1200	1/2.	enn	_			uneral Ho 186, Dav		26260		
	_		23a. Part1. Enter the disease, shock, or heart failure. L	or complication	ons that ca	used the d	eath Don	1			-			Approximate
	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)	a	P	rali	gna o (or ay a c	nt	Meli	noma	J		1	Interval Between Onset and Death
	nsit	듣		b.		mpe	un	Mo	N				1	
	certificate be executed nding physician and use as the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Que to	(or as a co	onseque	ence of):					
68760,	be e iciar buri	a	Cause (Disease or injury	<b>€</b> ₀										
387	cate phys	훘	resulting in death) Last	1		Due to	(or as a co	onseque	ence of):					
ox 6	ding se as	Ž l		L .										
Bo	eath c	lan												
P.O.	The law requires that the death ate has been signed by the etter page 2 should be detached for u	by Physicla	Part II. Other significant condi	tions contribu	ting to dea	th but not r	esulting in	the <i>u</i> nd	erlying ca <i>u</i> se gi	ven in Part I.		tobecco use co		the ceuse of deeth?
of Vital Records,	aw requi	Completed									24a. Was	an autopsy ormed?	ava	re autopsy findings ilable prior to ipletion of cause eath?
=		8									10	Yes 2∑ No	1 🗆	Yes 2□ No
ŽĮ,	Physicien: The this certificate ral director, page	Be	25. Was case referred to medic examiner?							26. Place of Dea				
Ť	hysic his ce	၉	1 ☐ Yes 2 No	Hospi	tal: 1 🗆 Inp	patient 2	□ ER/Outp	atient	3□ DOA Oth	ner: 4 ANursing H	ome 5 ☐ Resi	dence 6 □Oti	ner (Specify)	
ion c	After fune	atlon:		tigation	Ba. Date of (Month,	Injury Day Year)	28b. Tir Inj	me of ury	28c. Inju Wo M 1 □	ryat rk? IYes 2 □ No		how injury occu		
Division	al or Attences efter death	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide deter	not be mined 28	Be. Place o building	f Inj <i>ury -</i> At J, etc. <i>(Spe</i>	home, farr cify)	n, stree	t, factory, office		28f. Location ( City or To	Street and Num. wn, State)	ber or Rural	Route Number,
	To the Hospital or I within 24 hours efter To the Funerel Director Completely filled in the Indian of the Indian o	edical (	29a. Certifier 1X Certify (Check only one) 2 Medica	i Exeminer: (	n: To the be On the basi and manne	is of exami	nowledge, on ation and/	death or	ccurred at the til tigation, in my c	me, date and place, ppinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as sta and due to t	ted. the cause(s)
	To the To the Comp.		29b. Signature and title of certi	er //	1				29c. Licens	se number		29d. Date sight	d (Manth, D	ay, ¡Year)
				1/4/	0.				D 2	225/14	Mb	111	8/09	4
	3	-	30. Name and address of perso	Who countrie	ted course	of death /la	om 22a\ /T	Vno D-	71)				0/0	
			Michael Leath							enter, Wa	ldorf.	MD		
			ritchael Leathe	. I wood	11.D	· 1.	2070	JIU	OC	or, wa	Lucii j			

DHMH 16 Rev 6/95

Registrar

102004

			State of Maryland / Department of Health and Mental Hyg  1- For State Registrar  Certificate of Death	iene •g. No. 2004	37500
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  WALTER MAZELL STARLING  2. Date of Deat Month NOV		3. Time of Death
	Examir Funeral	er	Renaissance Garden at Riderwood Village Silver Spring  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	4c. County of Dea Montgon	
	Director		11 M 2 F Months Days Hours Min. (Month, Day,	Year) Co	th Carolina  10d. Inside City Limits
	h the Maryli or 28e-f sho	irector		0g. Citizen of What Co	1 ☐ Yes 2 🛣 No
036	be filed within 72 hours after death with the Maryland ital Hygiene. In the matural, or Items 23a or 28e-f show event, the Madical Examiner must be notified at	by Funeral Director	3 □ Widowed 4 □ Divorced   If Yes, Give   1 □ Yes 2 ★No Specify:	USA  14. Race - Ame Black, Whit  Specify: Wh	e, etc.
21215-0036	e filed within 72 ho al Hygiene. other than "natur vent, Ire Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  2 Electronics Wholesaler	16b. Kind of Business	
Maryland	2 should be fill and Mental H is marked officerumatic even	To Be			Zip Code)
Baltimore, Ma	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic or once.		1 🖾 Burial 2 Cremation 3 Removal from State Arlington National November 29,	20c. Location - City or	Town, State
Baltir	permit. F Departme Importar any injur		21. Signature of Funeral Service Lice See  22. Name and Address of Facility Francis J. Collins Funeral 500 University Blvd, W, Si	Arlington, Home Inc. lver Sprin	
	Physician /Medical Examiner	er.	23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponded in the cause of the cause o		Approximate Interval Between Onset and Death 6 months
8760,	icate be executed physician and s the burial-transit	dical Examiner	Hault tailure to thrive		
.O. Box 6	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	23d. Date of deli Month	ivery Day Year
Records, P.	w requires that been signed t should be det	þ	at in. Other argument consistence community to death but not resulting in the underlying cause given in Part I.	accoluse contribute to s 2 □ No 3 □ Pro	the cause of death?
Vital Rec		e Completed	a or the constant to select	prior to death?	topsy findings available completion of cause of
Division of Vit	Phys this al dii	To B	examiner?  1   Yes   2   Mo   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Mursing Home   5   Resider	nce 6 Other (Spec	pify)
Divis	or A lifter Direction by	al Certification;		use(s) and manner as	stated.
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	(Check only one)  2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, da and manner stated.  29b. Signature and title of certifier	te and place, and due	to the cause(s)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOVEEN PUTHUMANA, 3110 GRACEFIELD ROAD, SILVER		
	Sta Registr		astronomic and an area of the second of the		

		For State Registrar	State of	Marylar	-	artment of H rtificate of L		nd Mental H	ygiene	2001	37600
Physicia /Medica		Decedent's Name (First, Middle, L     William H		pett,	Jr.			2. Date of I Month Novem	Day	, 2004	5:00 A M
Examine		4a. Facility Name (If not institution, g 9216 Overlook Tr	ail			4b. City, Town, or Ft. Wash	ningto	n		County of Deat Prince	Georges
Funeral Director		5. Social Security Number 6. 228-09-0643  Usual Residence of Decedent	Sex 7 1 ★ M 2 □ F	. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of E (Month, Aug. 9	Birth Day, Year) , 191	9. Birti 2 Mar	hplace (State or Foreign untry) yland
the Maryland 28e-f show otilied at	ector	10a. State 10b. County	Georges		ty, Town or Lo				40m Ciair	zen of What Co	10d. Inside City Limits 1 ☐ Yes  No
23a or	al Dir	15746 Livingston	Road			10f. Zip Code	2060	)7	Tog. Citi.	USA	untry?
urs a	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed For 1 Tyes 2 If Yes, Give Year or Da	ces? 2 M∑No		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Orig n, Mexican, Specify:	in? (Specify Yes or I Puerto Rican, etc.)		14. Race - Ame Black, White Specify:	
within 72 ho liene. r than "natur the Wedical	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-	4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	ntion Juring most )	of working		us Gove	
unid be filled Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Las William Henry Ti		^.				's Name (First, Midd 'y Jane De	lle, Maiden	Sumame)	
and 2 sho lealth and I m 27 is me her treums		19a. Informant's Name/Relationship Daphene Jones -		201	9216			or Rural Route Num	shing	ton, MD	20744
t. Pages 1 rtment of H rtent: If Ite		20a. Method of Disposition  1	cify)	tate Tr	cemetery, crei inity N	matory or other place Memorial G	idns 1	Date .1-10-2004		dorf, M	
Deparation of the paratic para		21. Signature of Euneral Service Lic	ensee MOI	1391	\ <b>#</b> i	2. Name and Addres Intt Funer U. DUX	al Ho	me laldorf, M	D 206	04	
	dical Examiner	23a. Part Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, france, leading to annual date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	y one cause on ea  a Due to (c	ch line.	quence of):	Provista Failan	h	ardiac or respiratory	anost,		Approximate Interval Batween Onset and Death
0 0 0	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 Fet nt at time of	al death 3	Ectopic pregnancy Other (specify)			. 2	3d. Date of deli Month	very Day Year
igne bed	۵	Part II. Other significant conditions	contributing to dea	ath but not re	sulting in the u	nderlying cause give	en in Part I.		tobacco us	_	the cause of death?
The tay te has age 2	Completed						-		topsy formed?	24b. Were au prior to c death? 1 ☐ Yes	topsy findings available completion of cause of
this ald	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 N No  27. Manner of Death 1 N Natural 5 Pending investigati	28a. Date of (Month	-	ER/Outpatier 28b. Time o Injury	f 28c. Injury Work	at □ Nur	of Death Check on sing Home 5 Re 28d. Describe	sidence 6	Cther (Spec	Daughters Home
To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place	of Injury - At h g, etc. <i>(Speci</i>		reet, factory, office			(Street and own, State)	d Number or Ru	ral Route Number,
To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in I	edical	29a. Certifier (Check only one)  1 Certifying F	Physician: To the bar aminer, On the bar and mann	sis of examin	owledge, deat adon and/or in	h occurred at the tim vestigation, in my op	e, date and	place, and due to the cocumed at the time	e cause(s) e, ua e ano	and manner as piace, and due	stated. to the cause(s)
within To the comp	×	29b. Signature and title of certifier	R	0100		29c. License				signed (Month	
BIA		30. Name and address of person wh Thomas L. Fields				Print)			//	0 0	007
Stat Registra		31. Date filed (Month, Day, Year)  NOV 1	32. Re	Istrar's Sign	ature	bed					

		_ For	State of Maryland			Mental Hygie	ne	
		1 - State Registrar		Certifica	te of Death		No. 200	37601
Physic /Med	ical	Decedent's Name (First, Middle, Las	lown.		, Town, or Location of Dea	2. Date of Death Month	Day Year  S C County of Dea	19:59rm
Exami Funeral Director		5. Social Security Number 6. Se 218-14-18/6	sing + Reha	6. 5/	Un w Hill er 1 Year   If Under 24 Hrs	8. Date of Birth	Worce	- 1
Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County	10c. City	Town or Location	1/			10d. Inside City Limits 1 Yes 2 □ No
ING Z I Z I 3-UU30  be filed within 72 hours after death with the Maryland hall Hygiene. Id other than "natural", or Itema 23a or 28a-f show event, the Medical Exercities must be recitied at	Funeral Director	10e. Street and Number  Market 57	Feet  12. Was Decedent Ever in U.	10f. Z	ip Code 21863		Citizen of What Co	A
ours after de rat', or Item	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces?  1 XYes 2 No 194 If Yes, Give Year or Dates:	9   _	edent of Hispanic Origin? (5 ecrly Cuban, Mexican, Puer 2) No Specify:	to Rican, etc.)	Black, Whi	
7 2 2	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	life. DO NOT	ork done during most of wo	orking 168	b. Kind of Business	/Industry
aryiand < 1 < 1 < 1 < 1 < 1 < 1 < 1 < 1 < 1 <	To Be Co	17. Father's Name (First, Middle, Last)	unscad	11.00	T	me (First, Middle, Mai	iden Sumame)	mproyed
re, Ma		19a. Informant's Name/Relationship (7	SON (daughter 2006. PI	19b. Mailing Address lace of Disposition (Na	ss (Street and Number or R	Prince G	ity or Town, State,	UA. 23860
Datimor  permit. Pages Dep_rtment of Importent: If it any injury or o		4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen	nemoval from State	Vetcom 22. Name a	Com.	15-04 H Funcial H	tom.	
Physician		23a. Part1. Enter IT Isease, or comp shock, or heart failure. List and Immediate Cause (Fin disease or condition	plications that caused the death ne cause on each line.		de of dying, such as cardia		md,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)  Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence)  Due to (or as a consequence)	Jence of):	re			2-6ks.
ate be executed hysician and the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (c. as a consequence of d.					1-6K.
BOX 69 auth certific attending p for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic			23d. Date of de Month	livery Day Year
w requires that the de been signed by the should be detached	b	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the underlying	cause given in Part I.			o the cause of death?
The lay ate has page 2	Completed					24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of s 2 \( \text{No} \)
OT VITAL P Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			ath (Check only one)		
ing ing	atlon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 D 28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	Home 5 Residence 28d. Describe how i		city)
i Site	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At ho building, etc. (Specify	ime, farm, street, facto	ry, office	28f. Location (Stree City or Town, S		ural Route Number,
Hospital 24 hours a Funeral is	edical	29a. Certifier 1. ★ Certifying Ph (Check only one) 2 ★ Medical Exem	ysicien: To the best of my knowniner: On the basis of examinat and manner stated.	wledge, death occurre tion and/or investigatio	d at the time, date and plac n, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)
L To the Hospital within 24 hours a To the Funeral t completely filled	Me	29b. Signature and title of cartifier	QM, Q	29	D 544 2		Date signed (Mont	1
1 211		30. Name and address of person who		23a) (Type, Print)	D5442	51		
S Regis	tate trar	31. Date filed (Month, Day, Year) NOV 122	32 Aegistrar's Signat		1			

State of Maryland / Department of Health and Mental Hygiene 37602 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month RICHARD F. TURNER 11 2004 1:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ATRIA ASSISTED LIVING SALISBURY WICOMICO 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 1⊠M 2□F 212-01-3154 94 Director 07-22-1910 SALISBÚRY.MD. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits other traumatic avent, the Medical Examiner must be notified at 1X Yes 2 □ No MD WICOMICO SALISBURY Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a or 118 PRISCILLA STREET 21804 death , USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: ARMY 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No WHITE 3 Widowed 4 □ Divorced Specify: 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than 12 MANAGER SHIRT FACTORY permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic avent once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNKNOWN BENJAMIN W. TURNER LILLY B. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RICHARD P. TURNER - SON 3891 UNION CHURCH ROAD, SALISBURY, MARYLAND 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) ¢REMATORY OF DELMARVA 11-09-2004 DELMAR, DELAWARE 21. Signature of Funeral Service L 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Arenco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last physician as the burial-Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy ō Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ed by the a detached f ☐Yes 2☐No 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, Be Completed 1 Tes 2 No 3 Probably 4 □Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Wasan has certificate ha Division of Vital 1 ☐ Yes 2X No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification; To 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b, Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) buy MD Z1804 Joseph 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 9 2004 ocks Registrar

			r lease i	State of Marylan				-		•		
			1- For State Registrar 11-16-04	1. Per Phys. PGC				-	Reg. No	711116	37603	
7929			1. Decedent's Name (First, Middle, Last)	)	cr			2. Date of De	ath		3. Time of Death	
	Physici /Medi		Rosaline L. T	erry				Novemb	Da De,r	,	3:50 am	
	Examir	ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Deat	h		. County of Deat		
	Funeval		2100 Tiber Driv 5. Social Security Number 6. Sec		last birthdav)	Distric	t Heig	8. Date of Bir	th	cince G		
н	Funeral Director		1	]M 2∰F	Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year)	Year) 9. Birthplace (State or Foreign Country) 1970 Maryland		
	pug *		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Yown or Lo	scation		nug		77014141	10d. Inside City Limits	
	Maryia f sho	ō	Md. Prince G			t Height	<b>.</b> .				1X Yes 2 □ No	
	r 28a	Director	10e. Street and Number	reorge   DIS	SULIC	10f. Zip Code	<u> </u>		10g. Cit	izen of What Co	untry?	
	hours after death with the Maryland tural', or Itams 23a or 28a-f show all Exercities must be notified at		2100 Tiber Driv	7.E		20747			USA	Ą		
	er des Itams Itams	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	specify Yes or No to Rican, etc.)	)-	14. Race - Ame Black, White		
336	irs aft	by F	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1		1□Yes 2ሺ No	Specify:			Specify: Bla	ck	
21215-0036	72 hours after death with the Marylar natural", or itams 23a or 28a-f show diest Exeminal the notified at		15. Decedent's Edu (Specify only highest grade	ication	16a. Dece	dent's Usual Occup	ation	deina	16b. K	ind of Business/	Industry	
2	d within 72 ho giene. Ir then "natur The Modical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	iking				
421	Hygier othar ti		11th 17. Father's Name (First, Middle, Last)		Disa	abled	18 Mother's Nar	me (First, Middle,	Maidan	Sumamal		
au	e a la b €	To Be	Russell W. Terr	v			Mary J.			oumanio)		
Maryland	d 2 should be and Menta 7 is marked traumatic e	-	19a. Informant's Name/Relationship (Ty	*	19b. Mailir	ng Address (Street				r Town, State, Z	lip Code)	
	s 1 and 2 f Health itam 27 i	1	Mary J. Jenkins	(Mother)	2100	Tiber	Dr. Dis					
Baltimore,	of of		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R	Removal from State 20b. P	lace of Dispo emetery, crer	sition (Name of natory or other place	ce)	Date	20c. Lo	ocation - City or	Fown, State	
Ħ		1	*4 ☐ Donation 5 ☐ Other (**Epacify)  21. Signal A of Funeral Lervice Licen	Riv		e Pk. C					,MD.	
Ba	permit. Departr Importe any inji		Inspect	Inune	/	rone J.		Funera			NW 20011	
			23a. Papil. Enter the disease, or complished or heart failure. List only of	rrest,	ay sc.	Approximate Interval Between						
2	Pnysician		Immediate Cause (Final disease or condition		Carlioulminus assert						Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):								
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):								
	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. E. As Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):								
,092	te be executed ysician and ne burial-transit		resulting in death) Last									
6876	ā × ā	dlcal		J								
Вох 6	eath certificat attending phy I for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal			23d. Date of deliv	very				
	death e atte	Icla	in the past 12 months?				Month	onth Day Year				
P.O.	that the de ted by the a detached f	Phys	9 Unknown	9□ Unknown								
	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be delached for use as it	þ	Part II. Other significant conditions cor	ithbuting to death but not resu	ulting in the ui	nderlying cause give	en in Part I.				the cause of death?	
Sor	w requires t been signe should be	letec						24a. Was				
Re	The law ate has page 2:	Completed			au pe				sy rmed?	death?	topsy findings available ompletion of cause of	
ita		Be C	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath Check onl o		1 🗆 Yes	2 🗆 No	
ž <	g is	ဥ	1 105 22110	lospital: 1   Inpatient 2		t 3 DOA Othe	er: 4 🗌 Nursing H	ome 51⁄2 Resid	dence 6	3 □Other (Speci	ıfy)	
o uc	fing P. After t	lon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	k?	28d. Describe h	now injur	y occurred		
Division of Vital Records,	I or Attanding after death. Diractor: After I in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	M 1 ☐ Yes 2 ☐ No  28e. Place of Injury _ At home, farm, street, factory, office 2			28f. Location (Street and Number or Rural Route Number.					
Ω	alor As after I Dira	Certification:	4  Homicide determined	building, etc. (Specify	()	out, tautory, oou	4	City or Tou				
	To the Hospital or Attanding PP within 24 hours after death. To tha Funeral Diractor: After th completely filled in by the funeral	edical (	29a. Certifier 1 Certifying Phys	ng Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time.					cause(s)	and manner as	stated.	
	To the h within 24 To tha F complete	Medi	one)  29b. Signature and title of certifier	and manner stated.	TOTAL DESCRIPTION OF REAL PROPERTY.	29c. License				e signed (Month,		
ļ	Veitl Cor	-	A la signature and time of certifier	0			000910			1 ( - 10 - 8		
0			30. Name and address of person who co	ompleted cause of death (Item	23a) (Type.		100 110				0745	
4			Jafar Nazemian			Oxon H	ill Roa	d. Suit	te 2			
	Sta		31. Date filed (Month, Day, Year) NOV 1 2 2004	3 Registrar's Signal	ture							
	Registr	al	1404 T \$ 5004	Marie Marie	11						,	

		·	For State Registrar	State of Maryla		artment of H			ene 2001	4 3	7604	
	Physici	an	1. Decedent's Name (First, Middle, Last)	4. (T):1				2. Date of Death Month	Day	Yeer	3. Time of Death	
	/Medic Examin	al	Reginald I 4a. Facility Name (If not institution, give s Washington Adventist I			4b. City, Town, or Takana		November 2	2, 2004 4c. County o Mantega		1:55 A. M	
Ī	Funeral Director		5. Social Security Number 577–24-0494 6. Sex 12 M 2 F 82 Yrs.			If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day)   Hours   Min.   May 4, 192			Year) 22	9. Birthplace (State or For Country) Washington, D.(		
	and and		Usuel Residence of Decedent  10a. State 10b. County	10c. 6	City, Town or Lo	cation				100	f. Inside City Limits	
	Mary I she	tor	D.C.			Wa	ashingtan				1 <b>⊠X</b> es 2 □ No	
	h with the 23a or 28a	al Directo	10e. Street and Number 900 G Street, N.E.			10f. Zip Code	20002	10	og. Citizen of Wi U.S.A		y?	
036	should be filed within 72 hours after death with the Maryland of Menall Hygiene.  marked other than "natural", or litems 23a or 28a-f show marked other than "natural", or litems 23a or 28a-f show matic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:	'	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	Black	American White, etc Black	C.	
2	72 ho	eted		15. Decedent's Education 16a. Decify only highest grade completed) (Gi			turing most of wo	rking	6b. Kind of Bus	b. Kind of Business/Industry		
2121	d within giene or than	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)  College (1-4or 5+)  Security Grand					D.C. Government			
and	ld be file ental Hy ked oth ic event,	To Be C	17. Father's Name (First, Middle, Last) Hezeki	ah Tinsley			18. Mother's Nar	ne <i>(First, Middl</i> e, M Maria Dill	laiden Sumame, ard	)		
Maryland 21215-0036	and 2 should salth and Men n 27 is marke ier traumatic	-	19a. Informant's Name/Relationship (Ty), Rev. Alonzo Jackson (G		19b. Mailir 4901. I	ng Address (Street a	and Number of Ru treet Clin	ural Route Number. ton, Maryla	city or 720735	tate, Zip C	ode)	
Baltimore,	Pages 1 ient of Ho nt: If iter iry or oth		20a. Method of Disposition  †☆Burial 2 □ Cremation 3 □ R  *4 □ Donation 5 □ Other (Specify)	1	. Place of Dispo cemetery, cren ncoln Mar		tery Nove	mber 8,2014	Suitland			
Balti	permit. Departmitmportal		21. Signature of Funeral Service License	Indones		Name and Address		Rollins Fun Washington,		, INc. 019		
8760,	The law requires that the death certificate be executed  XI  If the has been signed by the attending physician and upper signed by the attending physician and upper signed 2 should be detached for use as the burial-transit	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Additional Cardiac Conditions as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								1r	pproximate iterval Between inset and Death	
O. Box 6	Ihat the death certific hed by the attending p detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year			
ds, P.	signed by	by	Vialata Malleta						_	co use contribute to the cause of death?		
Vital Records,		Completed	Chrus ?	Roual Front Que	ailun			24a. Was an autopsy perform	ed? pri	or to comp ath?	y findings available eletion of cause of	
Vita	ysician: The is certificate ha director, page	Be	25. Was case referred to medical examiner?	ospital:		Othe		ath (Check only one				
ō	Phys arthis eral dii	7; To	1 ☐ Yes 2 ☐ No	28a. Date of Injury	☐ ER/Outpatien 28b. Time of	1 3 DOX	4 LI Hursing F	lome 5 Resider 28d. Describe how				
<u>o</u>	Attending Physician: r death. ector: After this certifici by the funeral director, p	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		(? Yes 2 □ No					
Division of	al or Attens s after deatl il Director: od in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Stre City or Town,	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical (	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death	occurred at the time restigation, in my op	ne, date and place pinion, death occu	, and due to the car irred at the time, da	use(s) and mann te and place, an	ner as state d due to th	ed. e cause(s)	
	To the vithin 2 To the complet	Σ	29b. Signature and title of certifier			29c. License		29	d. Date signed (		y, Year)	
	(2)		30. Name and address person who co	modeleted cause of death of	unico			Rd. Roc	kville.	My.	20852	
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 1 2 2004	39. Alegistrar's Sig	nature &	L)	- ipi	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
-		0.01			7							

			For State	State of Maryland	Department of Health and Certificate of Death		C U U 4	37605
			Registrar  1. Decedent's Name (First, Middle, Las	t)	Certificate of Death	Reg. 2. Date of Death		3. Time of Death
	Physici /Medi		Susie E.	Thomason	7	NOV_	Day Year	7:58 A
	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of De	ath	4c. County of Death	
	Funeral		5. Social Security Number 6. S	A CIVENTIS  7. Age (In yrs. last	birthday) If Under 1 Year   If Under 24 H	Park rs. 8 Date of Birth	Montgo	MCTY place (State of Foreign
	Director	,	577 36 2472 1	OM 20 F 77	Yrs. Months Days Hours Mi	n.   8. Date of Birth (Month, Day, You	27 Cou	place (State of Foreign ontry) S : C
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location			0d. Inside City Limits
	Mary s-f sho	tor	MD Prince	Georges H	vottsville.			1 Yes 2 No
	or 28	Direc	10e. Street and Number	01	10f. Zip Code	10g.	Citizen of What Cour	ntry?
	s 23a	Funeral Director	1807 Longtel	low St.	20 78:	2	USA	
60	after de or item	Fune	11. Marital Status   1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White,	
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23e or 28e-1 show other treumatic event, the Madical Exercited must be notified at	d by	3 Widowed 4 □ Divorced	Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: B	ack
15-	in 72 ł	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	<ol> <li>Decedent's Usual Occupation         (Give kind of work done during most of w life. DO NOT use retired)     </li> </ol>	rorking 16t	. Kind of Business/In	dustry
212	should be filed within and Mental Hygiene.  s marked other then ", sumatic event, the Man	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Home make	c C	own Ho	Me
pu	be filed ital Hygi od other event, II	Be	17. Father's Name (First, Middle, Last)	- 1.	18. Mother's N	ame (First, Middle, Mai	den Sumame)	
Maryland	should ind Men i marke umatic	2	19a. Informant's Name/Relationship (7	-IWain	9b. Mailing Address (Street and Number of	13e11.	Keid	20774
	1 and 2 s Health an em 27 is other treu		Patricia Cal	b/Day	2102 Klimble to	CLII	ry or rown, state, zig	have Mid
ore,	0 0		20a. Method of Disposition  1 X Burial 2 Cremation 3	como	of Disposition (Name of tery, crematory or other place)		Location - City or To	wn, State
Baltimore,	Pag nent ant:		` 4 □ Donation 5 □ Other (Specify	Line	oln Mem. 11-	12-04 5	uitlan	(MD
Bal	permit. Departr Importe any inju		21. Signature of Funeral Service Life in	300,	22. Name and Address of Facility	WE Wa	tuneral	Heme
		$\vdash$	23a Part1. Enter the disease, or companies shock, or heart failure. List only	lications that caused the vath. Done cause on each line.	o not enter the mode of dying, such as cardi		311 000	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. (11	whomis		4	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of the	tur		
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequent	Grualony aus	wess		
	nd nd ransit	Examiner	that initiated events	С.				
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a consequence	ee of):			
687	ificate g physi as the b	Physician/Medical		d.	TE TO THE TOTAL CONTROL OF THE			
Вох	eath certific attending pl for use as t	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	uth 3 □Ectopic pregnancy		23d. Date of delive	•
.O.	the att	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)		Month	Day Year
<u>α</u>	that the dened by the a		Part II. Other significant conditions or	ontributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobaco	o use contribute to the	e cause of death?
rds	w requires been sign should be	ed by				1 ☐ Yes	2 ☐ No 3 ☐ Prob	ably 4 Downown
Vital Records,	e law requ has been je 2 shoul	ompleted				24a. Was an autopsy	prior to cor	osy findings available inpletion of cause of
al H		O				performed 1 ☐ Yes 2		2 🗆 No
Vit.	Physicien; This certifical rat director, p	o Be	25. Was case referred to medical examiner?	Hospital: 1 XInpatient 2□ ER/0	Other	eath (Check only one) Home 5 Residence	6 DOthor (Specif	
n of		n: T	27. Manner of D ath	7 1	D. Time of linjury at Work?	28d. Describe how in		7)
Division	ten leath tor: the	catic	Accident investigation  3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No	F		
DΙΛ	of or Attendent after death	Certification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	rarm, street, factory, office	City or Town, Si	and Number or Rura ate)	Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsician: To the best of my knowled	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occ	ce, and due to the cause	e(s) and manner as st	ated.
	To the H within 24 To the F complete	Medi	29b. Signature and title of certifier	and manner stated.	29c. License number			
)	0 ¥ 5 8		250. Signature and time a certimer	1	E614-	7	Date signed (Month, I	Say, rear)
2	(n)		30. Name and address of person who o	ompleted cause of death (Item 23a	(Type, Print)		1/0/0	20912.
			Nsreen Ko	ngo 7610	Carroll Ave 2	105 Tak	oma PK	MD
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 1 2 2004	32. Registrar's Signature	don't			
DH	MH 17 Rev 1/2		140 A T & 5004	prime.	goo			
				OR	IGINAL			

			For State Registrar			artment of Hotelin of L	Death	ental Hygien	תחול ב	37606
303	Physicia /Medic		1. Decedent's Name (First, Middle, La ANTHONY JOH	N VILLANI				2. Date of Death Month Da	- 10, 300g	3. Time of Death
6	Examin		4a. Facility Name (If not institution, given Pour Bull A Reg / OHA) 5. Social Security Number 6.5	medical c	CONTA (In yrs. last birthday)	4b. City, Town, or  5QC	150414		Licomic	
10	Funeral Director			XM 2□F	90 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Year, 10/24/191	4	PA
o o	Maryland e-f show ilied at	ctor	10a. State 10b. County Worce:		Oc. City, Town or Lo					10d. Inside City Limits  1X Yes 2 □ No
#	th with the M 23e or 28e-f ust be notifie	Funeral Director	10e. Street and Number 12750 Old Brid	dge RD		10f. Zip Code 2184	2		tizen of What Cou JSA	ntry?
% % % %	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 is marked other than "natural", or items 23e or 28e-f show treumatic svent, the Medical Examiner must be notified at	by Fune	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: K	** ** 1 1	Was Decedent of His f Yes, specify Cubar I ☐ Yes 2X No	spanic Origin? (Spec i, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: Wh	, etc.
1215-0036	in 72 hour n "natural dedical Ex	Completed t	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done d OO NOT use retired)	tion uring most of workin	16b. H	(ind of Business/Ir	ndustry
√ / ارح and 212	be filed with ital Hygiene. id other than svent, the N	Be Com	Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last	College (1-4or 5+)		er/Opera	tor		urniture n Sumame)	Store
√. V Marylar	2 should be filed withir and Mental Hygiene. Is marked other than eumatic svent, the M	ToE	Ignazio Villani 19a. Informant's Name/Relationship (	Type, Print)		-		Route Number, City		p Code)
_	s 1 and of Heall item 2		Anthony Villani  20a. Method of Disposition  1X Burial 2 Cremation 3		20b. Place of Dispo cemetery, crer	sition (Name of natory or other place	Da		ocation - City or T	own, State
n t h o ハ y Baltimore,	permit. Page Department of Importent: If any injury or once.		4 □ Donation 5 □ Other (Special 21. Sign at relot Fun and Service Lice	(y)		n Cemete . Name and Address	of Facility he	Burbage F	rlin, MD uneral l	
4	465 4 4		23a. Part1. Enter rie disease, or com shock, or hear failure. List only	plications that caused the	e death. Do not ent		<u>m St. Be</u>	<u>rlin, MD</u>	21811	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Acute Due to (or as a o	consequence of):	e isch	emia s	f left	les	48 hrs.
	uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):					
3760,	cate be executed oblysician and the burial-transit	icai	resulting in death) Last	Due to (or as a o	consequence of):					
P.O. Box 68760	To this Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 moeths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal déath 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	rery Day Year
	quires that n signed b uld be deta	by	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause give	n in Part I.	23e. Did tobacco		the cause of death? bably 4 □Unknown
Reco	The law requirence has been single has been single 2 should I	Completed	congestive	heart	- fail	عدو		24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
<u> </u>	icien: Th certificate rector, pag	a	25. Was case referred to medical				26. Place of Death		, 12.00	
>_	hysic nis ce I direc	To B	examiner? 1 Yes 2 146	Hospital: 1 Hipatient		t 3 DOA Othe	r: 4 Nursing Hom	ne 5 ☐ Residence	6 □Other (Speci	fy)
ОП	ding Physicien: The n. After this certificate hi funeral director, page		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day )	28b. Time of Injury	Work		8d. Describe how inju	ry occurred	
Division of Vital Records,	To the Hospitel or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	OB Place of Leive	r - At home, farm, str (Specify)		es 2 No	8f. Location (Street a City or Town, State	nd Number or Rur. 9)	al Route Number,
	ths Hospi in 24 hour the Funer pletely fille	Medical (	(Check only 2 Medical Exa	nysician: To the best of miner: On the basis of e and manner state	xamination and/or in	estigation, in my op	inion, death occurre	d at the time, date an	d place, and due t	o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	mo		29c. License	number 2093	29d. Da	te signed (Month,	Day, Year)
C	- (al 1		30. Name and address of person who	completed cause of dea		Print)	Assa			
<b>U</b>	(0+ ) Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar		· Sal	سطع	, MO .	1 000	
	Registr	_	NAV 192	nna la	k A.	- M -	Ĭ.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 11:26 a M 7, Nickarter Abiera Villanueva November 2004 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Holy Cross Hospital Silver Spring Montgomery SILVEY SULLING

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) Days 1⊠M 2□F 66 April 19, 1938 None Philippines Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Marvland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2712 Elnora Street 20902 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Asian 1 ☐ Yes 2 A No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Postal Worker Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Regidor Villanueva Eustaquia Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2712 Elnora Street, Silver Spring, MD 20902 Pomposa D. Villanueva/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Date 20a. Method of Disposition 20c. Location - City or Town, State November 10 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2004 Alexandria, Virginia Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. MINEMAIR 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Arrest Due to (or as a consequence of): Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Diabetes Mellitus, type II Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 😿 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred √ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide to the cause(s) and manner as stated. The control of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier SUME er D0030791 November 8, 2004

certificate be executed P.O. Box 68760 Division of Vital Records, Hospitel or Attending **Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

items 23a

'neturel', or

Hygiene.

permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygient Importent: If Item 27 is marked other the eny injury or other treumatic event

Physician

/Medical

Examiner

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After

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within 24 hours a To the Funerel D

the attending physician

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filed within 72 hours after

Baltimore, Maryland 21215-0036

Director

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Completed

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Certification:

Medical

injury or other treumatic event, the Medical Examiner must be notified at

Registrar

31. Date filed (Month, Day, Year) 1 0 2004

Jean-Pierre Faure,

M.D. 32 Registrar's Signature

dress of person who completed cause of death (Item 23a) (Type, Print)

8218 Wisconsin Avenue, Bethesda, MD 20814

		1- For Amend Item 3 p	State of Man	kland/02/027	artment of He 05dhb rtificate of D	ealth and N Death			004	376	80	
Physic	ian	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of 0 02:24	Death M	
/Med		William Wilson, Sr.  4a Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death						03	2004			
Exami	ner	4a. Facility Name (If not institution, give s 118 Flower Street			Berlin	Location of Death			4c. County of Death Worcester			
Funeral		5. Social Security Number 6. Sex		In yrs. last birthday	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	)		nplace (State or untry)	Foreign	
Director		227-40-8008 18 M 2 F 73 Yrs. Months Days					June 20			/A		
p .		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or L	ocation					10d. Inside City	y Limits	
Aaryla I sho	ō	MD Worcest		Berlin						1 ∰Yes	2 🗆 No	
the N 28a-	rect	10e. Street and Number			10f. Zip Code		1	10g. Citizer	of What Cou	untry?		
h with	Funeral Director	118 Flower Street			21811			U.S				
oms 2	iner	11. Marital Status	12. Was Decedent Eve Armed Forces?	ar in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp., Mexican, Puerto	pecify Yes or No- Rican, etc.)	14.	Race - Amer Black, White			
s after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 √ Yes 2 No If Yes, Give Year or Dates:	Army	1□ Yes 2□No	Specify:		Sp	ecify: Bla	ack		
If I I I I I I I I I I I I I I I I I I		15. Decedent's Edu	ident's Usual Occupat	tion		16b. Kind	16b. Kind of Business/Industry					
on 72 nic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	(Give	kind of work done du DO NOT use retired)	aring most of wor	king					
d with	S m	8th			Bus Contra			Board of Education				
Vidito	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Su	mame)			
y id	2	James Douglas, Sr.		10h Mail	ing Address (Street a	Lina Wi	1son ral Route Number, City or Town, State, Zip Code					
d 2 st d 2 st th and 7 is n traun		Margie Wilson/wife			Flower St				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,		
ie, Maly s 1 and 2 shou f Health and h item 27 is ma		20a. Method of Disposition			osition (Name of matory or other place		Date		ion - City or	Town, State		
Pages ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	temoval from State		s Cemeter	l l	0/2004	Berl	in, M	)		
DESIGNATION CONTROL VIGILIA CALA INCOME.  PERMIT. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "naturel", or liems 23a or 28a-1 show any injury or other traumatic event, the Marylasi Exprint must be natified at mose.		21. Signature of Fundred Service License		2	2. Name and Address	s of Facility						
0 88558		23a. Part1. Enter the disease, or compl		1	618 West	Road, Sa	lisbury,	MD 2	1801			
		shock, or heart failure. List only or	or respiratory are	rest,		Approximate Interval Betw Onset and D	veen					
Physician		Immediate Cause (Final disease or condition resulting in death)	Acc		CARDIA	1 /NZ	ARCTI	ONI		MMEDIE	TE	
/Medica Examine		Due to (or as a consequence of):								EN YE	APS	
Mr.	je j	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):						EN C		
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6 / 6U, ate be executed ohysician and the burial-transit		resulting in death) Last	Due to (or as a	consequence of):								
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DOX OO/ leath certificate attending phys	an/Med	IF FEMALE:	23c. If yes, outcome of						23d. Date of delivery			
n fa maga	ciar	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2 4□Pregnant at tir		□Ectopic pregnancy □ Other (specify)				Month	Day Y	'ear	
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g Phys er this	-	27. Manner of Death	28a. Date of Injury (Month, Day)	28b. Time				escribe how injury occurred				
Mending F death. ctor; After y the funera	atlo	1 Natural 5 Pending 2 Accident investigation	(10.6.101, 20)	11,017		res 2 □ No						
DIVISION for Attending after death. Director; After fin by the fune	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, s (Specify)	treet, factory, office		28f. Location (S City or Tow		iumber or Ru	ral Route Numb	oer,	
Hospitel of the hours of Funeral D Funeral D tely filled in		20a Cartifier 1D Cartifuing Phys	rsician: To the best of	my knowledge, der	ith occurred at the tim	e date and place	and due to the	cause(e) an	d manner as	stated		
DIVISION  To the Hospitel or Attent within 24 hours after deatt  To the Funeral Director; completely filled in by the	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	iner: On the basis of e and manner state	xamination and/or	nvestigation, in my op	inion, death occu	rred at the time,	date and pla	ace, and due	to the cause(s)		
To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier			29c. License	number		29d. Date s	igned (Month	n, Day, Year)		
( n		Jooth C.	Hohword	the ms.	DO	6241		11-	6-04			
MIT		30. Name and address of person who c		1.0	e, Print)	5.00	5 5	MANUI	4111	MD 2	188	
IVA		31. Date filed (Month, Day, Year)	HOLZWOZ 32. Registrar		D. 20:	3 JAOW	St. 51	VU FV		,,,,,,		
Regis	tate		004 Sen	was &	1 Spark	2						

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 8, 2004 0835 TERRANCE CHARLES WASKIN /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 7282 PEA NECK ROAD ST. MICHAELS TALBOT Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 67 Director 556-48-2503 JUNE 28, 1937 MICHÍGAN Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ? ie marked other then "naturel", or Items 23a or 28a-f show treumatic event, tra Modical Examiner must be nytified at 1 ☐ Yes 2 X No Director TALBOT ST. MICHAELS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7282 PEA NECK ROAD 21663 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: WHITE þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3 REALTOR REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RUSSELL WASKIN LILLIAN CRUTHERS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHLEEN D. WASKIN/WIFE 7282 PEA NECK ROAD, ST. MICHAELS, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition GATE OF HEAVEN CEMETERY 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 11/11/2004 SILVER SPRING, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 JOHN R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ma **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 the attending physician Certification: To Be Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home science 6 Other (Specify) 1 Yes 2 to 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) lilled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 Natural 2 Accident s after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C 150 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) 032136 o completed cause of death (Item 23a) (Type, Print) 2108 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

			State of Maryland / Depa	urtment of Health and Me tificate of Death		ne 2004	37611
ī	Dhysisia		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Carolyn Ann White		November	09 2004	2:37 PM
	Examin	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral		Doctors Hospita1           5. Social Security Number         6. Sex         7. Age (In yrs. last birthday)		8. Date of Birth	9. Birtho	George's  lace (State or Foreign
	Director		158−36−1915 1□M 2XF 57 Yrs.	Months Days Hours Min.	Aug. 12,	1947 Ne	w Jersey
	and		Usual Residence of Decedent         10c. City, Town or Lo.           10a. State         10b. County         10c. City, Town or Lo.	cation	<u> </u>		0d. Inside City Limits
	Maryl f sho	ţ	Maryland Prince George's	Lanham			1 ☐Yes 2 ☐ No
	n the	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Cour	ntry?
	J within 72 hours after death with the Maryland jiene rithan "natural", or Itams 23e or 28e-f show It e Madical Exercit et rastite resillad at		10513 Storch Drive	20706		United S	
	ltams	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	Vas Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
2-0036	urs af	þ	1 Never Married 2 Married 1 Yes, 2 Tho 3 Widowed 4 Divorced Year or Dates:	☐ Yes 2☐ No Specify:		Specify: B1	ack
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<u> a</u>	Alen Alen Itic	To Be	Allen Thomas Smith		Jennie	Rosser	
Maryland 2	ges 1 and 2 should to to the thank and Ment to the Ts marked or other traumatics.			g Address (Street and Number or Rural			Code)
	l and lealth om 27 her tr			.0513 Storch Dr., I		ID 20706 c. Location - City or To	Chata
9	Pages '		I District 2 Contentation 3 Different state	natory`or other place)		s. Location - City or To	own, State
saltimore,			'4 □ Donation '3 □ Other (Specify)  21. Signature of Funeral Service Licensee 22	Erematory 11/12/ . Name and Address of Facility Sta		Clinton, eral Home	MO
ñ	permit. Departr Importa any inji		John T. Steward HI	4001 Benning Rd.,			)19
Н	ж.		23a. Part / Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.				Approximate Interval Between
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XOX	death certifica e attending ph id for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	te		23d. Date of delive	iry
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ďS,	requires that the een signed by th hould be detache	d by	Partition significant conditions continuously to double but not resulting in the dr	deliying cadse given in r art i.	1 ☐ Yes		
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VItal	sician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
0	this aldu	은	1 ☐ Yes 2 No Hospital: 1 Impatient 2 ☐ ER/Outpatient				1)
	ling L. After Tune	tion:	27. Manner of Death  1. Matural 5 — Pending (Month, Day Year)  2. Accident investigation	28c. Injury at Work?  M 1 □ Yes 2 □ No	8d. Describe how i	njury occurred	
UIVISION	after death. I Director: After din by the funer	ifica	3 Suicide 6 Could not be			t and Number or Rura	l Route Number,
ā	ital or rs afte al Din ed in	Certification:	4 Homicide building, etc. (Specify)		City or Town, Si	(ate)	
	Hospital of the sale of the sa	edical	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or inv	occurred at the time, date and place, and estigation, in my opinion, death occurre	nd due to the cause d at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the Hos within 24 h To the Fun completely	Med	one) and manner stated.  29b. Signature and title of centier	29c. License number	29d.	Date signed (Month,	Day, Year)
	r s r ŏ		Il Ilms ms	D3 2261	111-	-9-04	
R	(10)		30. Name and address of person who completed cause of death (Item 23a) (Type, I	Print) ANNAPOLIC S	CAN	- m	20706
	Sta		31. Date filed (Month, Day, Year) 22. Registrar's Signature		(		
•	Registr	ar	NOV 1 2 2004 Reserve & American	W			

		•	For State Registrar	State of Marylan		t of Health and e of Death		jiene •g. No 2 0 0 4	37612
	Physici	-	1. Decedent's Name (First, Middle, Las	11110	วก		2. Date of Dea Month	th OB COL	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give PTINCE GETTALE  5. Social Security Number)  6. Se	street and number)  (x) 7. Age (In yrs.	4b. City,				Petrople nolace (State or Foreign
	Director		Usual Residence of Decedent	□M 2 AF 85	Yrs. Months	Days Hours M	8. Date of Birth	1919 Sout	Carolina
	the Maryla r 28a-f shov notified at	rector	MD         Prince (           10e. Street and Number         10b. County		y, Town or Location  orestville  10f. Zip	Code	1	0g. Citizen of What Co	10d. Inside City Limits 1 ☑ Yes 2 ☐ No untry?
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, I'm Medical Exertinal must be notified at ance.	Completed by Funeral Director	8408 Bonny Drive  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Amed Forces? 1	.S. 13. Was Deced		erto Rican, etc.)	U.S.A.  14. Race - Ameri Black, White Specify:	Black
21215-0036	d within 72 liene. piene. r than "nat I're Medici	ompiete	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 11th		16a. Decedent's Usua (Give kind of wor life. DO NOT us Domestic	rk done during most of	working	16b. Kind of Business/I	ndustry
Maryland 2	ould be fited Mental Hyg arkad othe	To Be C	17. Father's Name (First, Middle, Last) Unknown				Name (First, Middle, I Garris	Maiden Sumame)	
Baltimore, Mar	Pages 1 and 2 she nent of Health and int: if item 27 is mu iry or other traum.		19a. Informant's Name/Relationship (7.  Betty G. Walker/D  20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □  4 □ Denation 5 □ Other (Specify	aughter  20b. P		y Drive For	cestville,	; City or Town, State, Z  Maryland 2  20c. Location - City or 1  Brentwood, M	20747 Fown, State
Balti	permit. Departm Importa any inju		21, Signature of Fureral Stylice Licens	500	22. Name an 7474 L	d Address of Facility andover Roa	J. B. Jenk d Landove	ins Funera r, Maryland	1 Home 1 20785
8760,	Physician Medical Examiner  The private and private an	ical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	uence of):	lio me	a control	wat u	Approximate Interval Between Onset and Death
P.O. Box 68	ath certific ttending p or use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3 Ectopic pr			23d. Date of delin	very Day Year
	n requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions or	ontributing to death but not res	ulting in the underlying ca	ause given in Part I.	1	pacco use contribute to	\0
l Records,	The ate h page	Completed					24a. Was a autops perforr	ned? prior to o	opsy findings available ompletion of cause of
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hamilal 2			Death (Check only on		
Division of Vital	ling Phys	tlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 DO 28b. Time of Injury M	8c. Injury at Work? 1 Yes 2 No		ence 6 Other (Spec ow injury occurred	ify)
Divisi	tal or Attend s after death al Director:	Certification;	3 Suicide 6 Could not be determined		ome, farm, street, factory	r, office	28f. Location (St City or Town	reet and Number or Rui n, State)	ral Route Number,
	the Hospital or thin 24 hours after the Funeral Dir mpletely filled in	edical	29a. Certifier (Check only one)  (Check only one)	ysician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death occurred tion and/or investigation,	at the time, date and pla in my opinion, death o	ace, and due to the ca courred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
110	To the within To the	Σ	29b. Signature and title of certifier	haa -/	290	License number		9d. Date signed (Month	, Day, Year)
1	XIII.			2000	~~/	752261		1-9-04	
	THE STATE OF THE S		30. Name and Iddress of person who co	1.6	9711 A1	MARCIS	nol (	A phone on	n 20706
	Sta Registi		NOV 1 2 2004	and the state of	and a				

DHMH 17 Rev 1/2001

		·	1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artmen ertificat			and M		giene Reg. No.	004	37613
			1. Decedent's Name (First, Middle, La	st)						2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic		Katie	Mary Hunt	er Parham	Whit	low			Novemb		2004	6:45 A.M
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City,	Town, or	Location o	of Death		4c. C	ounty of Deat	h
		4	Fairland Nursing					lver	_			Montgo	
	Funeral		5. Social Security Number 6. S 410–42–2891	- 24	(In yrs. last birthday Yrs.	Months	Days	If Under a	Min.	8. Date of Birt (Month, Da	y Year)	9. Birt	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent		77				1	Novembe	r 28,	, A.	Labama
	/land		10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside City Limits
	Many t-f sh	to	Alabama Macon	n	Tuskeg	ee .							1 <b>X</b> Yes 2 ☐ No
	r 28g	Director	10e. Street and Number			10f. Zip	Code				10g. Citize	n of What Co	ountry?
	th wit	aD	818 Highland Hil	ll Drive			3608	33			Uni	ited St	tates
	ems ems	Funeral [	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Deced	dent of His	spanic Orig	gin? (Spec	cify Yes or No Rican, etc.)	- 14	Race - Ame Black, White	
9	or it	by Fu	1 Never Married 2 Married	1 □Yes 2 <b>X</b> N If Yes, Give	D	1 🗆 Yes		Specify:			1		Black
ğ	filed within 72 hours after death with the Maryland Hydjone. Ither than "natural", or teems 23a or 28a-f show ant, the Medical Evantaer must be notified at	q p	3 X Widowed 4 □ Divorced	Year or Dates:	150 Door	dont's Hou	al Ossusa	tion			16h Kind	of Business/	Industry
7	n 72 "nat	Completed	(Specify only highest gra	ade completed)	(Giv	edent's Usua e kind of wo DO NOT us	rk done d	uring most	t of workin	ng			Affairs
12	withi ene. than	шс	Elementary/Secondary (0-12)	2 years	-)	nsed 1			Nurs	se		ical Ce	
ס	filled Hygi othar ent, I		17. Father's Name (First, Middle, Last				T	18. Mothe	r's Name	(First, Middle,	Maiden St	umame)	
<u>a</u>	ould be t Mental I arked or atic eve	To Be	Willie Robert	Hunter				Ka	tie	Hall			
Maryland 21215-0036	S D E E	-	19a. Informant's Name/Relationship (	Турв, Print) (Daug	hter) 19b. Mail	ing Address	(Street a	nd Numbe	er or Rural	Route Numbe	er, City or T	Town, State, 2	Zip Code)
Ž	and 2 ealth a n 27 is		Veronica Lynn Par	ham-Dudley	6517	- 3re	d Str	eet,	N.W.;	Washi	ngton	, D.C.	20012
ē.	s 1 a of He itam itam		20a. Method of Disposition	30	20b. Place of Disp cemetery, cre	osition (Nar	ne of other place	)	Da	ate	20c. Loca	tion - City or	Town, State
Ĕ	Pages nent of I int: If its iry or o		1 XBurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Special		Ashdale	-			ov.13	3,2004	Tusk	egee,	Alabama
altimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	nsee	2	2. Name an	nd Addres	of Facilit	y O <b>mn</b> ar	y Mort	ician	e Inc	
m	a d E a d		Konemick	cuam		600 K	enned	y St	reet,	N.W.;W	ashin	gton,D	.c. 20011
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each line	the death. Do not er	nter the mod	le of dying	, such as	cardiac or	r respiratory ar	rest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Chronic	Obstruct	ive P	ulmoı	nary	Disea	ase			Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):								
	Examiner		Sequentially list conditions	b. Pneumor									
	р <del>‡</del>	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):							-	
	ecute and -trans	cam	that initiated events resulting in death) Last	C	consequence of);								
60,	cate be executed physician and the burial-transit	Ē		Due to (01 as a	consequence or,								
8760	cate t	dical		_ d									
9 X	The law requires that the death certific sie has been signed by the attending p page 2 should be detached for use as	w i	IF FEMALE:	23c. If yes, outcome of	of pregnancy						22	d Dato of dol	han.
Division of Vital Records, P.O. Box	atten for us	by Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2	Petal death 3	□Ectopic pr					230	<ul> <li>d. Date of deli</li> <li>Month</li> </ul>	Day Year
o.	that the de ed by the detached	ysic	1 ☐ Yes 2 🕱 No 9 ☐ Unknown	9□ Unknown	into or dodding		,001y)						
٦.	res that the signed by be detact	/Ph	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying c	ause give	n in Part I.		23e. Did to	obacco use	contribute to	the cause of death?
Sp	uires sign td be	Q P								118	/es 2□	No 3 ☐ Pr	obably 4 Unknown
Ö	w require been si should I	lete								24a. Was	an :	24b. Were au	topsy findings available
Re	sician: The law certificate has b irector, page 2 s	Completed									rmed?	prior to death?	completion of cause of
g	ifficat or, pa		25. Was case referred to medical					26 Place	of Death	1 ☐ Yes	2X No	1 U Yes	2□ No
>	Physician: r this certific ral director,	To Be	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 Inpatier	nt 2□ER/Outpatie	ent 3 DC	Othe	~		ne 5 Resid	/	Other (Spec	cify)
ō	g Phy er thi	Ë	27. Manner of Death	28a. Date of Injury (Month, Day			28c. Injury Work			8d. Describe I			,/
0	Attanding r death. actor: After by the fune	atlo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio		Year) Injury	М		es 2 □!	No				
<u>X</u>	Atta	tific	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home, farm, s	treet, factory	y, office		2	8f. Location (5 City or Tox		Number or Ru	ıral Route Number,
	To the Hospital or Attending Physician: The within 24 horus after death.  To the Funeral Director: After this certificate his completely filled in by the tuneral director, page	Certification:											
	lospi t hou uner uner		29a. Certifier 1 Certifying Pl	nysician: To the best o miner: On the basis of	f my knowledge, dea	th occurred	at the tim	e, date and	d place, a	nd due to the	cause(s) ar	nd manner as lace, and due	stated. to the cause(s)
	To tha H within 24 To tha F complete	Medical	one)	and manner stat	ed.								
	To the within To the Comple	2	29b. Signature and title of certifier			290	c. License	number 58962			Noven	signed (Montl iber (	n, Day, Year) <b>) , 2004</b>
•			- XUUV		<del></del>								, 2004
	16/		30. Name and address of person who			, Print)				ld Roa			
			Shashank G  31. Date filed (Month, Day, Year)		r's Signature		wnea	ton,	Mary	Tand 2	20902		
	Sta	te	NOV 1 2 201		. o organization								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2004 **Physician** WALTER WARREN WHITE NOV 5:26 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY ff Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Day, PEB. 9) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F 85 Yrs. 426-48-4629 MISSISSIPPI Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Itams 23a or 28a-f show the Medicul Evandi entrust Le notified at 1 ☐ Yes 2 ☐ No Director VIRGINIA **FAIRFAX** SPRINGFIELD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8320 GARFIELD CT. 22152 U.S.A Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Importent: If itam 21 is marked other the any injury or other traumairs assets. MANAGER FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WALTER WARREN WHITE SR. MAUDE ULMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BILL WHITE ( SON ) 4106 BREEZWOOD LN. ANNANDALE, VA 22003 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State \* 4 Denation 5 ☐ Other (Specify) NATIONAL CREMATORY 11-12-04 FALLS CHURCH, VA Fineral Service Licensee 21. Signature 22. Name and Address of Facility DEMAINE SPRINGFIELD CHAPEL 23a. Pa/1. Enter the disease, of complete shock, or heart failure. List only 5308 BACKLICK RD. SPRINGFIELD, VA 22151 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immédiate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OSTEOMYELITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): . attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the a 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1 🗌 Yes 2 **X**No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. Be 25. Was case referred to medical 26. Pface of Death (Check only one, Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 2 XNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 010123518 (VA) 08 2004 MD NATIONAL NAVAL MEDICAL CENTER 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) BETHESDA MD 20889-5600 WILLIAM E. BENNETT

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) NOV 1 2 2004



			T - For State Registrar	State of Maryland		artment of H		-	ene g. N.2004	37615
	Physici		Decedent's Name (First, Middle, Last)     KENNETH	WILSON				2. Date of Death Month NOV •	3	3. Time of Death 2:40A M
	/Medic Examir		4a. Fecility Name (If not institution, give s Shady Grove Ad	street and number)	ni+=1		Location of Death	1.000	4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Sex		-	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day,		thplace (State or Foreign buntry) Iaryland
	show	٥٢	Usual Residence of Decedent  10a. State 10b. County  MD Monto	,	, Town or Lo	cation				10d. Inside City Limits  1 ☐ Yes 2 ☐ No
	th the N or 28a-f	Director	10e. Street and Number			10f. Zip Code	village	10	g. Citizen of What C	
	leath wi	Funeral [	18728 Walker	s Choice Rd  12. Was Decedent Ever in U.S			0886	ify Yes or No-	U.S.A.	
980	72 hours after death with the Maryland naturel', or Items 23a or 28a-1 show disal Evanding must be incitified at	by	1 Never Married 35 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates: 74-		f Yes, specify Cubai 1 ☐ Yes 2 ☑ No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ican, etc.)	Black, Whit	
21215-0036	within ane. Ithen "	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12±h		(Give life. L	dent's Usual Occupa kind of work done d DO NOT use retired;	ition furing most of working )	9	6b. Kind of Business	
	be filed tal Hygie d other event,	Be Co	17. Father's Name (First, Middle, Last)		пар		18. Mother's Name		General	Maint.
Maryland	2 should be and Mental ie marked creumatic even	To	Charles H. W  19a. Informant's Name/Relationship (Ty)	*	10h Mailin	and descriptions of Chronical		a Mae		7.0.4
	and 2 sl tealth and m 27 ie r her treur		Marguerite Wil	son (Wife)	1872	8 Walke	rs Choic	e Rd.,	Montg.	<sup>Zip Code)</sup> 20886 Village,MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Monta Importent: If item 27 is marked any injury or other treumatic as once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Ga	metery, cren te of	sition (Name of natory or other place Heaven	Cem 11/	12/04	Silver	Spring, MD
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Liens	Sucred	22	Name and Addres	s of Facility SNO ash. St.	WDEN F	UNERAL H ville, M	OME, P.A.
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the death. e cause on each line.	9			respiratory arres	et,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):		.,01			hears
	cuted nd ransit	Examiner	Sequentially list conditions, tany leading to in reclate cause. Enter Underlying Cause (Disease or injury that initiated events	Renal	anne offi					years
8760,	cate be executed obysician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a conseque	ence of):					
.O. Box 68	ne death certifi the attending f hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 Usive birth 2 Fetal of the Pregnant at time of dead of the Pregnant at time of the Pr	déath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
s, p	quires that the signed by ald be detacted	by	Part II. Other significant conditions con	tributing to death but not resul	ting in the ur	nderlying cause give	n in Part I.		cco use contribute to	_
Vital Record		Completed						24a. Was an autopsy performe	prior to d	stopsy findings available completion of cause of
Vita	rysiclan: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ospital:		Othe	26. Place of Death (	Check only one)		
ion of	Attending Physiclan: r death. ector: After this certifici by the funeral director, i	atlon; To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	f-1	R/Outpatient 28b. Time of Injury	28c. Injury Work	at 28	e 5∐ Residend d. Describe how	ce 6 Other (Spec	oify)
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	eet, factory, office	28	f. Location (Stree City or Town,	et and Number or Ru State)	ıral Route Number,
	To the Hospital or A within 24 hours after To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my know er: On the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the time estigation, in my opi	e, date and place, an inion, death occurred	d due to the caus at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To t To t Com	Σ	29b. Signature and title of certifier	701	200	29c. License			. Date signed (Montl	
	1		30. Name and address of person who	noleted cause of death (Item :	23a) (Type, F	Print)	713	11	wenter	7,2004 mo 20850
	Sta	to	Delocah J St.  31. Date filed (Month, Day, Year)	32. Registrar's Signatu	990	) Medic	al cente	rpr. R	lockulle,	MO 20850
	Registr		NOV 1 0 200		19	Sparks	1			

		-	•	State of Maryland / De	partment of Health and ertificate of Death	d Mental Hygi		37616
	Physicia /Medic	al -	1. Decedent's Name (First, Middle, Last) ROLAND	- /	NDREWS III	2. Date of Death Month NOVENBE	Day Year 28 200	1
	Examin Funeral Director	e1	4a. Facility Name (If not institution, give stre 5800 Richardson Ro 5. Social Security Number 6. Sex 219–28–6554		Months   Davs   Hours   M	t	Dorcheste  Year)  4c. County of Deat  9. Bin Co 1932  Ma	
To co	2 >		Usual Residence of Decedent  10a. State 10b. County  MD Baltimore	10c. City, Town o		7100. 107	1332   180	10d. Inside City Limits 1 □ Yes 2 ☒ No
A contract of the contract of	3a or 28e-	i Director	10e. Street and Number 133 Fourth Avenue	- 1	10f. Zip Code 21227		g. Citizen of What Co USA	ountry?
	rz nous aller dean with the maya, neturel', or Items 23s or 28e-f shov odical Examinationst be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Air Force	<ol> <li>Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 No Specify:</li> </ol>	(Specify Yes or No- lerto Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
-C121	than	Completed	15. Decedent's Educat (Specify only highest grade c	ion ompleted) 16a. De (G liii	ecedent's Usual Occupation live kind of work done during most of the BONOT use retired)	working 1	6b. Kind of Business	
<u>a</u>	should be filed ind Mental Hygi i marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Roland Edward Andre	ws, Jr.	18. Mother's P Sara	Name (First, Middle, M Frances To	faiden Sumame) dd	-
Š	s I and 2 snd if Health and item 27 is ma other treum		19a. Informant's Name/Relationship (Туре, Joyce Andrews – dau	ghter 133	ailing Address (Street and Number or  Fourth Avenue, H	alethorpe,	W.W	
_	rage ment o ent: If ury or		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem  '4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	Meadowr	sposition (Name of crematory or other place)  idge Mem. Park  22. Name and Address of Facility	/2/2004	Elkridge,	MD
E E	Depart Import any inj	1	23a. Part1. Enter the disease, or complica shock, or hearth in b. List only one		Gary L. Kaufman F 7250 Washington B			21075 Approximate Interval Batween
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence)	artery de	scase		Onset and Death
760,	ite be executed ysician and he burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):	Mellitus			
. Box 68	death centifica e attending ph od for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	ivery Day Year
ds, P.	uires that the de signed by the a ild be detached f		Part II. Other significant conditions contri	buting to death but not resulting in th	e underlying cause given in Part I.		accoluse contribute to s 2 1 No 3 1 Pi	o the cause of death?
	ine iaw requires mat the ate has been signed by th page 2 should be detache	Completed				24a. Was ar autopsy perform 1 Yes 2	y prior to death?	utopsy findings available completion of cause of 2 No
Division of Vita	ysicien: is certific director.	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Magner of Death  1 Natural 5 Pending investigation	spital: 1 Inpatient 2 ER/Outpi 28a. Date of Injury (Month, Day Year) 28b. Tim Inju	atient 3 DOA Other: 4 Nursin	Death (Check only one ig Home 5 Reside 28d. Describe ho	nce 6 X Other (Spe	erdson load
Divisi	To the Hospitel or Attending Pn within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Str City or Town	reet and Number or R. , State)	ural Route Number,
:	To the Hospitel or A within 24 hours after or To the Funeral Direction properties of the completely filled in by	Medical (	29a. Certifier 1 Certifying Physic (Check only one)	sian: To the best of my knowledge, or: On the basis of examination and/or and manner stated.	leath occurred at the time, date and plor investigation, in my opinion, death o	ace, and due to the ca eccurred at the time, da	tuse(s) and manner as	s stated.  to the cause(s)
	withi Com	Σ	29b. Signature and title a certifier	ar-	29c. License number D 2164	9	VC V6UBER	29, 2004
	011		29a. Certifier (Check only only) 29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who com SAMBANDAN BAS 31. Date Nito Worth, Pay 2004	pleted cause of death (Item 23a) (Ty KACAV 3455 VA	Print)  1-KEW AVE /	BALTIMOR	E MD2	1229
	Sta Regist		31. Date 110 19 3h. 0 2004	32. Registrar's Signature	Sporks			

			1 - State of	f Maryland / Depa Ce	artment of Health and Nartificate of Death	Mental Hygi	ene 0 0 4	37617
			Decedent's Name (First, Middle, Last)			2. Date of Death	ı	3. Time of Death
	Physici /Medi		William Charles Arr	old		Month 1 1	25 2004	10:50AM
	Examir		4a. Facility Name (If not institution, give street and nu		4b. City, Town, or Location of Death		4c. County of Death	
1			208 Merganser Court		Chester		Queen A	nne
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	Q Riet	nplace (State or Foreign untry)
	Director		217-16-6122 <sup>1図M 2□F</sup>	80 Yrs.	Months Days Hours Min.	(Month, Day, 1 7 / 2 1 / 1	924 Ball	timore,MD
	pu *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	anation.			
	show	5	MD Queen Anne	Chester	CallOT			10d. Inside City Limits 1 ☐ Yes 2X☐ No
	death with the Maryland ms 23a or 28a-f show trivet be notified at	Funeral Director	10e. Street and Number	01103001	100 7'- O-1-	1.0		
	with	급			10f. Zip Code		g. Citizen of What Co	untry?
	eath	erai	208 Merganser Court		21619		14. Race - Amer	ion Indian
40		ä	Armed Fo	rces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
936	hours after cural, or ite	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes If Yes, Gir 3 ☐ Widowed 4 ☐ Divorced Year or D	e ates:	1 ☐ Yes 2 ☐ No Specify:		Specify: W	hite
Õ	2 ho	Completed	15. Decedent's Education	16a. Dece	dent's Usual Occupation	. 16	6b. Kind of Business/I	ndustry
215	hin 7	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1)	-4or 5+)	kind of work done during most of work DO NOT use retired) Shop M	anager		
2	ad wil	Con	12		er Diesel Mecha	nic L	easeway	Trans.
b	al Hy d oth	Be (	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Ma	aiden Sumame)	
<u>la</u>	Ment Ment arkac	To I	Howard Arnold		Ethel	Enos		
Maryland 21215-0036	2 should be filed within 72 hours and Mental Hyglene. Is markad other than "natural", 'aumatic evant, the Mudical Exe	1 3	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Run			
	and ealth n 27 er tr	- 1	Patruchia Arnold/Spou		Merganser Cour	t, Ches	ter, MD	21619
ore	of H of H if Iter		20a. Method of Disposition  UBurial 2 □ Cremation 3 □ Removal from	20b. Place of Dispo cemetery, crei	sition (Name of Instory or other place)	Date 20	Dc. Location - City or T	own, State
<u>Ē</u>	Pag ment ant:		4 □ Donation 5 □ Other (Specify)	Loudon	Park Cemetery 1	1/29/04	Baltim	ore, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Ilem 27 Is marked other than "natur any injury or other traumatic event, Its Mudical once.		21. Signature of Funeral Service Licensee	22	Name and Address of Facility	allings	Funeral	Home, PA
ш	70 F 9 9		1 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	[]	St 111 Mountain Rd	. Pasad	ena. MD	21122,
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	us d the death. Do not ent ach ine.	er the mode of dying, such as cardiac of	or respiratory arres	st,	Approximate Interval Between
	Physician	8 1	Immediate Cause (Final disease or condition	Joion Cai	u			Onset and Death
	/Medical		resulting in death)  Due to	or as a consequence of):		-1.11		
	Examiner		Sequentially list conditions, b					
	p ii	ine	if any, leading to immediate cause. Enter Underlying cause. Enter Underlying that initiated events c.	or as a consequence of):			1	
(	ecute and -trans	Examiner		A)				
50,	oe ex cian cian	Ē	Due to	or as a consequence of):				
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dicai	d					
9	ding p	Me	IF FEMALE:	nome of programmy	= 546		4 -	
Вох	attend attend for us	Physician/Me	in the past 12 months?		Ectopic pregnancy		23d. Date of deliv Month	rery Day Year
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P.0	requires that the de een signed by the a nould be detached f	-Ph	Part II. Other significant conditions contributing to de	ath but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds,	sign d be	d b		•	,,	1 ☐ Yes		bably 4 DUnknown
Ö	> 0 70	ete				- II	12	. –
Records,	e tar has je 2	Completed by				24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
a							No 1□Yes	2□ No
Vital		Be	25. Was case referred to medical examiner?  Hospital:		On	(Check only one)		
of	Phys	<u>۲.</u>	1 162 5 100	npatient 2 ER/Outpatien of Injury 28b. Time of	1 3 DOA 4 Nursing Ho	me 5 Residence 28d. Describe how	ce 6 Other (Speci	fy)
on	ding h h. After funer	ti lo	1 Natural 5 Pending (Mont	of Injury 15, Day Year) 28b. Time of 15 Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	zod. Describe riow	injury occurred	
Division of	Attending r death. ector: After by the funer	lica	2 □ Could not be	of Injury - At home farm str		28f Location (Street	et and Number or Run	al Route Number
Οį	after Dire	Certification:	4 Homicide determined 200. Place buildi	of Injury - At home, farm, str ig, etc. <i>(Specify)</i>	oot, radiory, onloo	City or Town,	State)	ai i loute (4umber,
_	spita ours neral fillec		29a. Certifier 1 Certifying Physician: To the	best of my knowledge, death	occurred at the time, date and place,	and due to the caus	sa(s) and manner as s	tated
	24 h 24 h e Fur	edical	(Check only 2 Medical Examiner: On the band many	sis of examination and/or in-	restigation, in my opinion, death occurr	ed at the time, date	e and place, and due t	o the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier		29c. License number	29d	. Date signed (Month,	Day, Year)
	X	1	It The Co	1.0	037064		11/29/04	
	10	1	3/ Name and Indress of person who completed caus	of death (Item 23a) (Type			111-1101	70-30
	V		James Chamberlain M		ve Pt. Rd., #10	7 5+00	ensvilla	MD 21666
	Sta	te	31. Date filed (Month, Day, Year) . 32. R	egistrar's Signature	, , , , , , , , , , , , , , , , , , ,	, Juev	CIISVIIIE	, MD 21000
	Registr		NUV3 0 2004 )	Serva &	Son de			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 004 37618 Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Yeer ano/Medical 4a. Facility Name (If not inelitution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months Days Hours Min. Director 919 -56-036 Usual Residence of Decedent the Maryland worle 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "netural", or items 23a or 28a-f ehov other traumatic event, the Medical Examinar must be notified at 1 FYes 2 No Director man 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 625 20688 SF death Funerai 12. Was Decedent Ever in V.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 20 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nany Injury or other traument. Elementary/Secondary (0-12) College (1-4or 5+) 19 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) mo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nar Punabout 675 -OOP Date Dolomans hus band 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 119-3-04 4 □ Donation 5 □ Other (Specify) Chematory 21. Signatur and Fun ral Service Licensee 22. Name and Address of Facility 1232 Midvalley Dr. Jessey 18434 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Priysician /Medical Due to (or as a consequence of): **Examiner** RESPIRATORY INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine METS burial-transit BREAST The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Records, P.O. Box 68760 Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Po in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9☐ Unknown 9 ☐ Unknowń Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 🗀 No 1 Yes 21 No 1 Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No 2 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Merdono 11/29/04 20060638 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Hospital Road Mendonca Prince Frederick Maryland Dr. Nayantara 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

hysicia /Medica xamine		1. Decedent's Name	e (First, Middle, La	st)		Certificate of	Dodin	2. Date of De	Reg. No.		3. Time of Death
		MicHA	BEL ALI	BRIGHT				Month NOVEMB	Day	Yeer <b>2004</b>	
LAGITHITIE				e street and number)		4b. City, Town,	or Location of Death			ounty of Deat	
		2409 Tion				Lansdow			Ва	ltimore	2
eral ector		5. Social Security N		M 2□F	jө (In yrs. last bir	thday) If Under 1 Year Months Days		8. Date of Bit (Month, Da	rth ay, Year)	9. Birti Co	hplace (State or Fore untry)
, 		217-58-02 Usual Residence of		51				10-21-	1953	Mary	land
		10a. State	10b. County		10c. City, Tow	n or Location					10d. Inside City Limi
	ecto	MD	Baltimo	re	Lansd						1 ☐ Yes 2½ ☐ 1
	2	10e. Street and Nun 2409 Tion		Ant 2P		10f. Zip Code				n of What Co	untry?
	Funeral Director	11. Marital Status	csta Ru.	12. Was Decedent		21227	Hispanic Origin? (Sp	ecify Yes or No	U.S.	· A •	ican Indian
	Be Completed by Fur		ed 2. Married 4. □Divorced	Armed Forces?  1 XYes 2 !  If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub	an, Mexican, Puerto Specify:	Rican, etc.)		Black, White	o, etc.
	etec	(Speci	15. Decedent's Edify only highest gra		16a.	Decedent's Usual Occup (Give kind of work done	during most of work	ina	16b. Kind	of Business/I	ndustry
	dm	Elementary/Secon	ndary (0-12)	College (1-4or 5		life. DO NOT use retire	d)	9			
9	ပိ	17. Father's Name (	First, Middle, Last)		lec	chnicial Eng	18. Mother's Name	a (First Middle			n Station
3	10 B	Joshua Al	bright				Lucille			inano,	
		19a. Informant's Na	me/Relationship (	Type, Print)	19b.	Mailing Address (Street	and Number or Rura	al Route Numbe	er, City or T	own, State, Zi	ip Code)
-	]-	Nicolasa		t/ Wife	240	9 Tionesta	Rd Apt 3E	Lansde	wne M	0 2122	7
1		20a. Method of Disp 1 ☐ Burial 2-5		Removal from State	20b. Place of cemeter	Disposition (Name of y, crematory or other place	cθ)	Date		tion - City or T	
once.		* 4 □ Donation	5 ☐ Other (Specif)	1)	Bayvie	w Crematory		4-04	Balt	imore,	MD
ouce		21. Signature of Fur	leral Service Ligen	DOMO OC	1	Ambrose Fu 1328 Sulph	ss of Facility Ineral Hom	e of La	nsdow	me	
	1	23a, Part1, Enter th	e disease, or com	plications that caused	the death Don	1328 Sulph	ur Spring	Rd. Ar	butus	MD 21	
an	4	Immediate Cause (F	Final		•	ot enter the mode of dyir		or respiratory ar	rest,		Approximate Interval Between Onset and Death
al		disease or condition resulting in death)			TIVE 14	EART FAIL	LURE				LYEAR
r		Convention to the	disinon	MORBIT							LOVEARS
	ner	Sequentially list con if any, leading to imr cause. Enter Under Cause (Disease or in that initiated events	mediate lying	Due to (or as a	a consequence o	of):					4640
200	Examiner	Cause (Disease or in	ast	C						1	
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DHMH 17 Rev 1/2001

& Sporks

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 22, 2004 **Physician** MARIE 11:50AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1809 COVINGTON STREET BALTIMORE CITY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Days 1 □ M 🗶 🗓 F 84 218-09-7453 Yrs. Director 10/18/1920 CLEVELAND OH Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic evant. It e Medical Examiner must be notified at Director MD BALTIMORE CITY XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1809 COVINGTON STREET 21230 or items 23e U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXVo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2\ No Specify: WHITE à XX Widowed 4 Divorced natural Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME is 1 and 2 should be filed voil Health and Mental Hygie item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANTHONY KUSHNER SOFIE KUNTZ ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) MARY A. BRASHEWITZ - DAUGHTER 1545 SULPHUR SPRING ROAD, ARBUTUS, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State to XXBurial 2 ☐ Cremation 3 ☐ Removal from State CEDAR HILL CEMETERY | 11/24/04 BALTIMORE, MD A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility FINK FUNERAL HOME, PA 21. Signature of Funeral Service I. any i FINK KELLYX GREGORY #MU1148 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 23a. Part i Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, the problem of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consacuance of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the Part II. Other signific int conditions contributing type ath but of esulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ Wo 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 No of Vital Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: ို 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ★ esidence 6 Other (Specify) 27. Manner of Death

1. Natural

2. Accident 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28c. Injury at Work? 28d. escribe how injury occurred After Division s after decal Diractor: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a
To the Funeral C
completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29d. Date signed (Monthy Day, Year) who completed cause of death (Item 23a) (Type, Print) 30. Name and dress of 205 MID Annapolis 32. Registrar's Signature State Registrar

25,36,31,394

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004 37621 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** : 40 AM 2004 MARTIN ALFERSTEIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE BALTIMORE, MD (IT' UNIVERSITY OF MARYLAND MEDICAL SYSTEM If Under 1 Year If Under 24 Hrs. 8. Date of Birth NOV.6, 1938 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 219-26-2740 66 Director Usual Residence of Decedent 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or iteme 23a or 28e-f showeny injury or other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No BALTIMORE Director BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA 7 HURSTON COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REAL ESTATE BROKER 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) ALPERSTEIN DOROTHY DAHNE REUBEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7 HURSTON COURT - BALTIMORE, MD 21208 SUSAN ALPERSTEIN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 11/28/2004 HAR SINAI CEMETERY OWINGS MILLS, MD 4 Donation Other (Specify) 21. Signature of Fun 22. Name and Address of Facility SOL LEVINSON & BROS., INC. uneral Service Lice see 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PROSTATE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ierel Director: After this certificate has been signed filled in by the funeral director, page 2 should be der Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 Yes 2 No 1 Tyes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩0 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death s after death. 1 BNatural 5 Pending 1 TYes 2 □ No М 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number DEA 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AU4176435515753 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo UNIVERSITY MARKEMER MEDICAL 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Amend is take of merry talk de 836 pal-1 m30 04 Heralth and Mental Hygier) [] [] 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ruz coe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner 4c. County of Death Baltinore land 7. Age (In yrs. last birthday) 78 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 XM 2 ☐ F Director Yrs 02/25/1926 Maryland Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner rust be notified at Maryland Baltimore 1 ☐ Yes 2X No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2121 Windsor Garden Lane Apt. D-543 21207 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1044 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 XYes 2 No 1944 If Yes, Give Year or Dates: d 2 should be filed within 72 hours after of the and Mental Hygiene.
27 Is marked other than "natural", or Her traumatic event, I're Medical Examiner. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Black 3 → Widowed 4 □ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Brick Layer Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Bertina Piader Herbert Briscoe Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s nent of Health an Woodlawn, 2Md 07 Department of Health a Important: If item 27 Is any Injury or other trat once. Charlotte B. Woods / Daughter 2121 Windsor Garden Lane Apt. D-543, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify Garrison Forest Ceme. 12/02/2004 Owings Mills, Maryland ure of Funeral Service Chenses 22. Name and Address of FacilityThe Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** openia Sequentially list conditions, for auto-instructions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29d. Date signed (Month, Dey, Year) who completed sause of death (Item 23a) (Type, Print) 30. Name and address of person 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 3 0 2004 Registrar

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ı	Physic		1. Decedent's Name (First, Middle, Las SHIRLEY GRAY	BOND				2. Date of Death Month NOVEMBER	Day	Year 2004	3. Time of Death
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Baltimore,	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Funeral Service Licens	9			ddress of Facility	E FUNERAL PIKE BALT	SERVI	CF.	
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	To the Hospital or Al within 24 hours after or To the Funeral Direct completely tilled in by	dicai C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sicien: To the best of	f mv knowledge, dea	th occurred at th	ne time, date and p	place, and due to the cau occurred at the time, date	sa/s) and ma	inner as sta	ed.
	o the Prithin 24 or the Framplets	Medi	one)  29b. Signature and title of certifier	and manner star	ted.		cense number		and place,		
)	F 3 F 8		\ ADD to	٠. ك			62023	1			2004
			30. Name and address of person who co	ompleted cause of de		, Print)					
	4		AYOJELE ERIN					tuenue, Bac	TUMON	e M	D 21229.
45	Sta Registr	te ar	31. Date filed (Month, Day, Year) NOV 3 0 20	32. Registra	A STATE OF THE PARTY OF THE PAR	poo	uls				

SHIRLEY" BOND

			1 - For State Registrar	State of Maryla	nd / Depa		ealth and M	lental Hygi		37624
			1. Decedent's Name (First, Middle, Las	)		-		2. Date of Death		3. Time of Death
	Physici /Medio		Mable F. Baker					Month 1 1	25 200	
	Examir		4a. Facility Name (If not institution, give				Location of Death		4c. County of Dea	
			Mariner Health				n Burni		Anne Ar	
	Funeral Director		235-18-0590	x	s. last birthday).	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/8/1	9. Bi 920 W.	rthplece (State or Foreign Country) Virginia
	land Dw		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumetic event. The Medical Eventral Letrofills of an once.	to	MD Anne Ar	undel Je	ssup					1 ☐ Yes 2 XNo
	or 284	Director	10e. Street and Number			10f. Zip Code	<u> </u>	10	g. Citizen of What C	ountry?
	23e viet b	al	7810 Clark Roa	d D-71		20794			USA	
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	U.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spanic, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	rs aft	by F	1 ☐ Never Married ② Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	☐ Yes 2, No	Specify:		Specify:	White
21215-0036	2 hou	ed	15. Decedent's Edu	ucation	16a. Deced	ent's Usual Occupa	ition	11	6b. Kind of Business	s/Industry
215	hin 73	Completed	(Specify only highest grad	fe completed)  College (1-4or 5+)	(Give	kind of work done d OO NOT use retired)	uring most of worki	ing		
21	ygiene /giene er the	Con	12		Lab T	ech/Kooj	per	Me	etal Man	ufacturing
Ind	be fill d oth even	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		aiden Sumame)	
<u>ya</u>	ould I Men narke netic	2	Unknown	0.1.1			Unknov			
Maryland	d 2 st th and 7 is n treun		19a. Informant's Name/Relationship (T)  Charles A. Bak						City or Town, State.	
	1 and Healt Hem 2		20a. Method of Disposition	20b.	Place of Dispos	sition (Name of			oc. Location - City of	
ou	ages ant of it: If ii y or c		1 ☐ Burial 2 🖾 Cremation 3 ☐ F	Terrioval from State   M	cemetery, crem etro C	natory`or other place rematory			Baltimor	
Baltimore,	arith. Parithe outen		21. Signature of Funeral Service Licens			Name and Address	111/4.	-		
ä	Depa Depa Impo any i		Musch, Oli	Hallerd	) 31		3	Pasad.	s runera ena, MD	1 Home, PA
	Fnysician /Medical Examiner	er	23a. Parl1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, from the cause. Enter Underlying Cause (Disease or injury	ications that caused the deane cause on each line.  a. Due to (or as a consect.)  Due to (or as a consect.)	uence of):	er the mode of dying	n, such as cardiac o	r respiratory arres	t,	Approximate Interval Between Onset and Death
.O. Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \)	Due to (or as a consect d	nancy al death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
<u>P</u> .	d by the	Phy	9 ☐ Unknown  Part II. Other significant conditions co	atributing to dooth but not re	aultina in the	d-4:	- in Donal	02a Did taba		
rds,	es pe pe	Completed by	7 .	uctive pulm		,	nın Parti.			o the cause of death?
Record	aw requir as been s 2 should	plete		// /				24a. Was an	24b. Were a	utopsy findings available
Ä	The lavate has	mo						autopsy performa	prior to death? aNo 1 ☐ Yes	completion of cause of
Vital	ien: artifica ctor, j	Bec	25. Was case referred to medical examiner?				26. Place of Death			
of	Attending Phyeicien: The I ir death. ector: After this certificate ha by the funeral director, page	2	1   Yes 2 \( \) \( \) Yes 2 \( \) \( \) Yes 2 \( \) \( \) Yes 2 \( \) Yes 2 \( \) Yes 2 \( \) Yes 2 \( \) Yes 3 \( \) Yes 3 \( \) Yes 3 \( \) Yes 3 \( \) Yes 3 \( \) Yes 4 \( \) Yes 3 \( \) Yes 4 \(	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	at 2	ne 5 Residence 28d. Describe how	ce 6 Other (Spe injury occurred	cify)
Division	tel or Atteners after deathers by Director:	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, stre	et, factory, office	2	28f. Location (Stree City or Town,	et and Number or R State)	ural Route Number,
	To the Hospitel or Atten within 24 hours after deal To the Funerel Director: completely filled in by the	edical	one)	sician: To the best of my kn ner: On the basis of examination and manner stated.	owledge, death ation and/or inv	estigation, in my opi	inion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
	Viith To COIT	Σ	29b. Signature and title of certifier	1/14		29c. License		290	. Date signed (Mont	h, Day, Year)
	1		Dem	IND			8958	//	121/0	Ý
_	り		Daliet Juny	empleted cause of death (Itel	141	3 Anna	holy Rou	1 #100	oclent	m MD21113
	Sta Registr		31. Date fled (Month Day, Year) NOV 3	32. Registrar's Sign	ature	8-				

DHMH 17 Rev 1/2001

Mabel Baker

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 37625 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year DONALD ROWDEN 1045 /Medical NOVEMBER 22 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept 5, 1 9. Birthplace (State or Foreign **Funeral** 1 √M 2 □ F Days Months Hours 263-36-7970 73 Yrs. Director Ĩ931 Michigan Usual Residence of Decedent the Maryland 10a. State 10b. County 10c, City, Town or Location 7 is marked other than "netural", or items 23e or 28e-f show traumatic event. The Modical Examinat must be notified at 10d. Inside City Limits FLDirector 1 ☐ Yes 2√ No Highlands Sebring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 605 Barcelona Drive 33875 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 Worean If Yes, Give Year or Dates: Conf1 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No à Specify. 3 Widowed 4 Divorced Conflict White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Deportment of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any njury or other traumatic event, the Walls. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) President 4 Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alvin J. Bowden Annette J. Brozak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janette A. Bowden - Wife 605 Barcelona Dr. Sebring, FL 33875 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11-29-04 4 □ Donation 5 □ Other (Specify) Lake Forest Crematory Avon Park, Florida 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Morris Funeral Chapel 307 S. Commerce Ave. Sebring, FL 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician VALVULAR HEART DISEASE. 20 YEAR /Medical Due to (or as a consequence of) Examiner 26 VERGS CORONARY HEART DISEASE . Sequentially list conditions, a y loading to initialize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed 2 WEEKS SEPSIS Due to (or as a consequence of): Box 68760 the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 0 in the past 12 months? Month 4 Pregnant at time of death Day Year 5 Other (specify) 1 Yes P.0. detached 9 Unknown 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 Yes 2 No 1 Yes Division of Vital 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 25 No Hospital: P 1 Inpatient 2 ER/Outpatient 3 DOA Dale of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Dev. Year) NOVEMBER 22 2004 RES- 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AWORI JEREMIAN 600 NORTH WOLFE BALTIMORE MARYLAND 21287. STREET HAYANGA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 3 0 2004 Registrar

DHMH 17 Rev 1/2001

	_		1 - For State Registrar		Maryland / De	partment of ertificate of		and Mental I	Hygien Reg. N	Z U U U	37626
	Physici /Medic		1. Decedent's Name <i>(First, Middl</i> e, Elizabeth	Last) OCCUTI				2. Date of Month November		ay Year	3. Time of Death 8:05 A. M
1	Examir		4a. Facility Name (If not institution,	give street and numb	oer)	4b. City, Town,	or Location o	of Death	4	c. County of Dea	th
			Chester Manor	Nursing H	ome		ertown			Kent	
f	Funeral			5. Sex 7. 1 ☐ M 2 🖾 F	. Age (In yrs. last birtho	Months Days		24 Hrs. 8. Date of Min. (Month	Birth Day, Year	9. Bir	thplace (State or Foreign
L	Director		185-05-8286 Usual Residence of Decedent		98 Yrs	•		Jan.	29,19	906   Sco	ttland
	iand ow		10a. State 10b. County		10c. City, Town o	Location					10d. Inside City Limits
	Many in sh	to	Florida St. P	etersburg	Pasa	dena					1 ☐ Yes 2 No
	r 28e	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	ountry?
	h witi		1454 Corey Way			337	'07			U.S.A.	•
	deat	Funeral	11. Marital Status	12. Was Decede		3. Was Decedent of	Hispanic Orio	in? (Specify Yes or	No-	14. Race - Ame	
9	after or Ite	/Fu	1 Never Married 2 Married		XI No	1 ☐ Yes 2 ☑ No		, Puerto Rican, etc.;	'	Black, Whit	
21215-0036	ural',	d by	3₺ Widowed 4 Divorced	Year or Date	es:					Specify: Whi	te
5	"nat	Completed	15. Decedent's (Specify only highest	Education grade completed)	(G	cedent's Usual Occu	during most	of working	16b. F	Kind of Business	Industry
2	withir ene. then	dmo	Elementary/Secondary (0-12)	College (1-4	or 5+)	DO NOT use retir	•			m + 1 1	
d 2	filed within 72 hours after death with the Maryland Hygiene. ythar then "naturel", or Items 23e or 28e-f show ant, Itte Medical Examinar must be molified at		17. Father's Name (First, Middle, La	ust)		Beauticia		r's Name (First, Mia	Idle Maide	Textil	es
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If itam 27 is marked other then "natural", or Items 23e or 28e-f show or other traumetic avant, Itie Medical Examinar must be notified at	To Be	James Prow					abella Gi			
ary	should that Ment s markadumetic s	-	19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Address (Stree					Zip Code)
	and 2 salth a n 27 is		Lewis Donald Bo	ccuti (S		3 Waterma				ryland	
ore	of He fitan		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3	Domewal from St.	20b. Place of Di	position (Name of rematory or other pla	ace)	Date	-	ocation - City or	
altimore,	Pag ment ant: h		'4 □Donation 5 □ Other (Spe		Baltimon Crematon	rematory or other place e/Washing	ton	2-1-2004	Laur	el, Mar	vland
Balt	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other ance.		21. Signature of Funeral Service Lic	ensee /	7	22. Name and Addr itzke Fun 630 Edmon	ess of Facility era1 H	ome of Ca	tonsv	ille, I	nc.
	x T		23a. Part1. Enter the disease, of co shock, or heart failure. List on	implications that cau	sed the death. Do not	enter the mode of dy	ing, such as o	ardiac or respirator	y arrest,	re, m	Approximate
	Physician		Immediate Cause (Final disease or condition		ronory	ant.	em	disc	A A 6		Interval Between Onset and Death
	/Medical Examiner		resulting in death)		as a consequence 1):			(00)			YES
	LAMITHE		Sequentially list conditions,	b. =							
	led nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of):					-	
	al-trai	Examiner	that initiated events resulting in death) Last	c Due to (or	as a consequence of):						
8760,	icate be executed physician and the burial-transit	dlcal		d							
9	tifical ig phy as th	led									
Box	death certific attending p	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor		B Ectopic pregnanc	·v			23d. Date of deli	very
	that the death cer ed by the attendin detached for use	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		t at time of death	Other (specify)			-	Month	Day Year
P.0	d by tetach	Phy	Part II. Other significant conditions								
Records,	es ign be	ed by	Faith, Other significant conditions	contributing to death	n but not resulting in the	underlying cause gr	ven in Part I.		d tobacco≀ ∐Yes 2		the cause of death?
000	aw requas been 2 should	Completed						24a. W		24b. Were aut	topsy findings available
		E O						— au pe 1 ☐ Yes	topsy rformed? 2 No	death?	ompletion of cause of 2 No
Vita	ysician: This certificate director, pag	Be (	25. Was case referred to medical examiner?				26. Place o	of Death (Check onl			
ot	di di	2	1 ☐ Yes 🛕 No	Hospital: 1 ☐ Inpa		ent 3LJ DOA		sing Home 5 Re	sidence	6 □Other (Spec	ify)
u	ding h. After fune	llon	27 Manner of Death  1 Natural 5 Pending		njury 28b. Time Day Year) Injur	Wo		28d. Describ	e how injur	ry occurred	
Division	I or Attending after death. Director: After in by the fune	flca	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	be Jac Blace of	Injury - At home, farm,		Yes 2 □ N		/Stroot an	od Number or Du	ral Route Number,
	al or / after I Dire d in b	Certification:	4  Homicide determine	building,	etc. (Specify)	stroot, ractory, office		City or 7	own, State	)	ar noute ivumber,
	pspita hours inara y fille		29a. Certifier 1 Certifying F	hysician: To the be	st of my knowledge, de	ath occurred at the ti	me, date and	place, and due to th	ne cause(s)	and manner as	stated.
	To the Hospital or At within 24 hours after of To the Funaral Direct completely filled in by	ledical	one)	aminer: On the basis and manner	s of examination and/or	investigation, in my	ppinion, death	occurred at the tim	e, date and	place, and due	to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier		44.	29c. Licens			29d. Dat	te signed (Month	Day, Year)
)			1/1/	1	- MD	DO	051	186	/	1/1/104	
	10		30. Name and address of perso wh		f death (Item 23a) (Typ	a, Print) Wdg B Ch	L.	415			
	Sta		And flow Fevguson 31. Date filed (Month, Day) Year)	MD 120.	Special RD F	ada is cr	ies text	own MD	216	20	
	Registra	ar	31. Date filed (Month, Day, Year) NOV 3 0 200	14 Bane	strar's Signature	sporks	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 19a per Inf (838 12/02/04dhb)
Foramend Items 9,15,16a,5,17,19a, 5,20a,27,14 Friith and Mental Hygiene Certificate of Death

Certificate of Death

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Booker Yeer Bett 0120 AM November /Medical 2004 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balt )chns Hopkins Hospita | Baltimere | If Under 24 Hrs. | 8 Date of Birth | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign MD Country) **Funeral** 1 ☐ M 2 🛱 F 62 Yrs. Director 217-40-5731 Dec 8, Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location in then "neturel", or items 23a or 28a-f show the Medical Evaniner must be notified at 10d. Inside City Limits MD Baltimore Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5533 Midwood Avenue death v Funeral 21212 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: black à Specify 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unle 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 I e marked other then ", any injury or other traumatic event, the Mesones. Elementary/Secondary (0-12) College (1-4or 5+) unk 12 unk 0 Secretary Dept. of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Henry Cheeks Daisy Wright 19a. Informant's Name/Relationship (Typa Print)

Tia Booker/daughtel Booker

Tia Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk 5533 Midwood Avenue, Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation SHOther (Specify) 21. Signatur Finanzi San e Licensee Ronald S. Wade, State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Physician 24-48 hours /Medical Due to or as a consequence of): **Examiner** Multi Organia Due to (or as a consequence of): 2-3 Days Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Acute Respiratory Distress Syndreme hours certificate be execu Due to (or as a cons - uence of): Box 68760 Physician/Medical as the l 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Impatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural
2 Accident 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 MO November 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Baltimore, MD Mathew Augustine MD 600 North Wolfe 31. Date filed (Month, Day, Year) 32. Registrar's Signature State south NOV 3 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 11em 2 per phys 9837 11-30-04 vt. State of Maryland / Department of Health and Mental Hygiens (1).

Certificate of Death

37628 1 - For State Registrar Reg. No. 2. Date of Death 11-21-2004 1. Decedent's Name (First, Middle, Last) **Physician** .15:15 pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMOREIMD BALTINORE If Under 1 Year If Under 24 Hrs. Min. S. Date of Birth (Month, Day, Year 3-20-1960) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F Yrs. Director 216-62-6199 MARYLÁND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad othar than "natural", or itams 23a or 28a-f show othar traumatic evant, the Madical Examinar must be notified at 1 XYes 2 No Director N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2930 McELDERRY ST. 21205 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2XXVo Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if itam 27 is markad othar than ' Elementary/Secondary (0-12) Coltege (1-4or 5+) -12-HOMEMAKER -0-DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HARRY BARKSDALE DORIS PARKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TARA BARKSDALE (DAUGHTER) 2930 McELDERRY ST. BALTIMORE, MARYLAND 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 Removal from State permit. Page Department o important: if any injury or injury or METRO CREMATORY Ower (Specify) 11-26-2004 BALTIMORE, MARYLAND 4 Donation eral Service kick see JUNATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part1 Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting death) Pnysician /Medical Due to (or as a consequence of) Examiner HIV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed burial-transit STAGE RENAL DISEASE END Due to (or as a consequence of Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical as the 9Sn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? GASTROINTES TIME BLEEDIN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 **▼**Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy 2 No 1 Yes or Attending Physician: after death. Diractor: After this certifications 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Impatient P 2 ER/Outpatient 3 DOA funeral 28c. Injury at Work? 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide vithin 24 hours.
To the Funeral Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

GHAZALEH ARAM 31. Date filed (Month, Day, Year) NOV 3 0 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 EASTERN 32 Registrar's Signature

SUNSVA

BALTIMORE MD

State of Maryland / Department of Health and Mental Hygien 0 1 1 - For State Registrar 37629 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 24 **Physician** 2004 ROBERT BONOLIS 3:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Rossville Rosedale Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 212-54-7618 55 Director 7/29/1949 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, it a Medical Examples must be notified at MD Baltimore Rosedale 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1203 64th St. 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ž☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) 0 Driver permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygie Importent: If item 27 Ia marked other t any injury or other traumatic avent Transportation 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Arthur Jerome Bonolis Anges Huff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Bonolis/Wife 1203 64th St. Baltimore MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1🌠 Burial 2 □ Cremation 3 □ Removal from State Holy Rosary Cemetery | 11/29/04 Baltimore 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Cvach/Rosedale Funerl Home 21. Signature of Funeral Service Licensee 1211 Chesaco Ave Baltimore MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ceselow variale disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** amore Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner The law requires that the death certificate be executed attending physician and for use as the burial-translt Drobete Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) 4 Pregnant at time of death Division of Vital Records, P.O. the 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 Yes 2 No Be Completed Deelm 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Director: After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D 29a. Certifier 1😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WD D 31464 04 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Balt. HASITMI 821 N. Entero 88 Sonte 308 mD 21201 SHOALIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State	State of Maryland	Department of Certificate			/ U   U   U	37630
			1. Decedent's Name (First, Middle, L.	ast) ^	Ochimoate	or Death	2. Date of Death		3. Time of Death
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H	Funeral	-	5. Social Security Number 6.	Sex 7. Age (In yrs. last		Year If Under 24 Hrs. Pays Hours Min.	8. Date of Birth (Month, Day, Year	9. Bin	thplace (State or Foreign
L	Director	- 1	219-16-6140 Usual Residence of Decedent	1 M 2 XF 92	Yrs.	2,0	12-24	11 NE	orth Carol in
	show		10a. State 10b. County	10c. City, T	own or Location				10d. Inside City Limits
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	death with the Maryland ims 23s or 28e-f show	Dire	10e. Street and Number	4/6 A. 00, 11.	10f. Zip Co	1 D	10g. C	itizen of What Co	ountry?
	death ims 23	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Deceden	t of Hispanic Origin? (Spe Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whit	erican Indian,
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anc	e d la la la la la la la la la la la la la	o Be	Tamos Gat	ting		Dais	7. Toro	lan 2	
ary	ges 1 and 2 should t of Health and Men ff item 27 is marke or other traumatic		19a. Informant's Name/Relationship	(Type, Prin Daughter)	19b. Mailing Address (S	treet and Number or Rura	I Route Number, City	or Town, State, 2	Zip Code)
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baitimore	Pages 'nent of thint: if ite		1  Burial 2 □ Cremation 3 1 Donation 5 □ Other (Spec	☐Removal from State	etery, crematory or othe	rplace)			
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			23a. Part1. Enter the disease, or con shock, or heart failure. List ont	nplications that caused the death. E y one cause on each line.	Do not enter the mode o	f domo, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
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01 <	l or Attending Physician: after death. Director: After this certification in by the funeral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/			ne 5 🗆 Residence	6 Other (Spec	cify)
	ding P	ion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	b. Time of lnjury M	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	iry occurred	
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	ro the vithin 2 ro the complex	Med	29b. Signature and title of certifier	and manner stated.	29c. L	cense number	29d. D	ate signed (Monti	h, Day, Year)
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ĺ	Ġ		30. Name and address of person who	-73 -00	2		217 10	7	
	Sta	te	31. Date filed (Month, Day, Year)	33 STREET  32. Registrar's Signature	Pattin	ne My	21218		
	Registr		NOV30	2004 Beneva	19 Apro	eld			

ORIGINAL

Registrar
DHMH 17 Rev 1/2001

74			Unpend Item 23a,27,28a-1 per me C							37632
			1. Decedent's Name (First, Middle, Last)				2. Dete of De Month		У 3	. Time of Death
	Physicia /Medica	_	CHARLES GORDON BELL, Jr.				NOVEME	_	2004	11:48 A.M
	Examine	r	4a Fecility Neme (If not institution, give street end number)		1	4b. City, Town, or L				
			6401 PULASKI HIGHWAY	الريا If Under	1 Vagr	BALTIMOR If Under 24 Hrs.	T .		na	(0)
ı	Funeral Director	-	5. Sociel Security Number $212-96-3328$ $^{6. \text{ Sex}}$ $^{7. \text{ Age (In yrs. lest birthde})}$ $^{7. \text{ Age (In yrs. lest birthde})}$ $^{7. \text{ Note of the second}}$ $^{7. \text{ Note of the second}}$	Months	Days	Hours Min.	8. Date of Bir (Month, De April	24, 196	9. Birthplace Country) New	Jersey
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1	28a-f st	Director	Maryland Anne Arundel Arnol  10e. Street end Number	10f, Zip	Code			10g. Citizen of		1 □ Yes 2 X No
4	38.0	בַּ	1144 Greenhill Road		21	.012			S.A.	
1		runerai		3. Was Deced		lispenic Origin? (Sp an, Mexican, Puerto	pecify Yes or No		ce - American I	Indian,
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4	marke	2		iling Address	(Street	end Number or Rui			, State, Zip Coo	de)
•	oer trau	Ĭ	Eleanor Bell (mother) 1144	Green	hil:	1 Road A	rnold,	Marylan	d 2101	2
	oth and a		20a. Method of Disposition 20b. Place of Dis	position (Nan rematory or o	ne of ther plac	ce)	Date	20c. Location	- City or Town,	State
00000	int: if		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Morelan	_			L1-24-0	4 Baltin	nore. M	arvland
	Depertrumports any Injuries		21. Signature of Funeral Service Licensee	Mitche	ell-		l Funera	al Home.	Tnc.	
	hysician		23a. Pert1. Enter he disvase, or complications that ceused the death. Do not a shock, or heart fail, e. List only one cause on each line.					-	Ap	proximate erval Between set and Death
	/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)  Narcotic, cocaine Due to (or as a constitution of the condition of the condit		1col	nol intox	ication		1 8 4 1	
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or Attanding	within 24 hours after death To the Funeral Director: complately filled in by the	Certifications	3 ☐ Suicide  3 ☐ Suicide  4 ☐ Homicide  6 【X Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)  Motel	street, factory			28f. Location (S City or Tov	Street and Number, State) 640	Pulas	oute Number, S <b>ki Hwy.,</b>
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		-	30. Name end eddress of person who completed causer (deeth (item 23e) (Typ	e, Print)	J. 11			- 40 A TIL		
₹ N	State	(	31. Dete filed (Month, Day, Year)  22. Registrer's Signature	111 PE	NN S	STREET, B	ALTIMOR	E , MAR	YLAND 2	1201
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DHMH 16 Rev 6/95

				partment of Health and Mer	_	711114	37633
	9		Decedent's Name (First, Middle, Last)		Reg. Date of Death	No.	3. Time of Death
	Physic /Medi		Alfred J. Burgan,			Day Year 26, 2004	
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	11:50 a <sup>M</sup>
		*	2438 Clydesdale Road	Finksburg		Baltim	oro
20	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.   8. [	Date of Birth		
н	Director		216-16-9021 <sup>1⊠M 2□ F</sup> 80 Yrs.		Month, Day, Ye		lace (State or Foreign try) vland
	p .		Usual Residence of Decedent		7111 1/	, 24 Hai	удани
	show	_	10a. State 10b. County 10c. City, Town or L	ocation		10	Od. Inside City Limits
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	72 hours after death with the Maryland "naturel", or Itams 23a or 28a-f show calcal Examinar must be notified at	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?
	ath w 23a		2438 Clydesdale Road	21048		U.S.A.	
	ar des	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No-	14. Race - America Black, White, e	
36	s afte	by Fi	1 Never Married 2 Married 1 May Yes 2 No	1 ☐ Yes 2 ▼ No Specify:	,,	Specify:	316.
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쟌	72 ina	Completed	15. Decedent's Education (Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of working DO NOT use retired)	16b.	. Kind of Business/Ind	lustry
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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Mar Important: If item 27 le marke eny injury or other traumatic once.		20a. Method of Disposition 20b. Place of Disp	osition (Name of Date		Mary 1 and Location - City or Tox	
no	ages ant of t: If i		1 XBurial 2 Cremation 3 Removal from State cemetery, cre	matory or other place)			
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			23a. Part 1. Effer the disease, or complications that caused the death. Do not en	INE FUNERAL HOME Rei			136
	4400000		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final		piratory arrest,		Approximate Interval Between Onset and Death
1	Pnysician /Medical		disease or condition resulting in death) a	1 C PANcientie	Con	cer	24+5
	Examiner		Due to (or as a continuence of):	1.1			2
		r.	Sequentially list conditions,  Dual to for an a consequence off:	er res			2405
Vit.	utad Insit	ri Li	If they bearing to time ediate cause. Enter Underlying Cause, Disease or injury				•
	execu n and al-tra	Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of):				
8760,	ate be executad physician and the burial-transit	dical	d				
9		edic	0.				
Вох	that the death certified by the attending parteched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliver	
	death e atte d for	icia	in the past 12 months?	□Ectopic pregnancy □ Other (specify)			Day Year
o.	t the	hys	9 ☐ Unknown 9 ☐ Unknown				
ري ص	The law requires that the death certific site has been signed by the attending p rage 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
Records,	quira n sig uld b	De De			1 🗌 Yes	2. No 3 □ Probal	bly 4 □Unknown
8	s been si should t	lete		2	4a. Wasan	24h Were autons	sy findings available
8	The ta	Completed			autopsy performed?	prior to comp death?	pletion of cause of
Viital	eicien: The law certificate has b irector, page 2 s	Be C	25. Was case referred to medical		Yes 2000	lo 1 ☐ Yes 2	!□ No
>	yeici s cer direct	0	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	26. Place of Death (Che nt 3 DOA Other: 4 Nursing Home		5 DON (0 (1)	
Division of	g Ph er thi	La l	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at 28d. E	Describe how inj		
0	ndin ath. r: Aft e fun	atio	1 Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
N N	ar de recto	tific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str		ocation (Street a	and Number or Rural I	Route Number,
ā	tal or A s after al Director	Certification:	4 ☐ Homicide Scientific building, etc. (Specify)		ity or Town, Sta	fe)	
	To the Hospital or Attending Physicien: The within 24 hours after death.  To tha Funarel Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check only (Ch	n occurred at the time, date and place, and du	ue to the cause(	s) and manner as stat	ed.
	the H in 24 in 8 F plete	Medical	(Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at t	tne time, date ar	nd place, and due to the	ne cause(s)
	To T To t	Σ	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Da	ay, Year)
)			I / Um what.	1) 7-97 6	9 1	11/29/0	24
	-11		30. Name an address of prison who completed cause of dea (Item ≥ a) (Type.	Print)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	12/270
	1041		morce (ino ). When a	9 5/6 M R/h	i Fol 1	3016 1	in
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		)		
	Registra	ar	NOV 3 D 2004 Garage A	1			

DHMH 17 Rev 1/2001

ORIGINAL

			Tor State of Man		artment of H	lealth and	Mental Hyg	iene	27621
			Registrar  1. Decedent's Name (First, Middle, Last)	Cei	rtificate of	Death	2. Date of Dea	eg. <b>12</b> 0 0 4	37634 3. Time of Death
	Physici /Medic		ALVIN		BERNSTE	IN	NOVEMB	ER 27, 20	
	Examin		4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL		4b. City, Town, o	BALTIMOF		4c. County of D	N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (I	In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth	17,8200	Birthplace (State or Foreign
L	Director		078-24-6360 1¼ M 2□F Usual Residence of Decedent	74 Yrs.			JUL.2,	1930	NY
	farylan stow	ō		0c. City, Town or Lo	ocation	BALTIMOF	) C		10d. Inside City Limits 1    1 Yes 2 □ No
	or 28a-	by Funeral Director	MD N/A  10e. Street and Number		10f. Zip Code	DALTINO		0g. Citizen of What	, <u>, , , , , , , , , , , , , , , , , , </u>
	s 23a	erai 🛭	3900 N. CHARLES STREET, #52		Was Decadest of h	21218	Engain Vac or No	14 Page A	USA merican Indian,
ဖွ	or item	Fun	11. Marital Status  1 □ Never Married 2 ★ Married  1 □ Never Married 2 ★ Married  1 ★ Yes, Give		1 ☐ Yes 2 ☐ No		Specify Yes or No- to Rican, etc.)	Black, W	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-1 show he Modicel Examitter in ust be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		dent's Usual Occur			Specify: 16b. Kind of Busine	WHITE pss/Industry
215	ithin 72 ne. "ne nem "ne	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo d)	orking		STAMPS
	filed w Hygier other th	Be Cor	17. Father's Name (First, Middle, Last)	V.P.	OF FINAN		me (First, Middle, I		& TRADING
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic svent, It would Examitate matter traumatic stem.	To B		BERNSTEIN		RUTH			ROTHBERG
Mar	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Type, Print)  LILA BERNSTEIN / WIFE	19b. Mailir 3900	ng Address <i>(Street</i> N. CHARL	and Number or R _ES_STREE	ura#19119Number T - BALT	City or Town, State	e, <i>Zip Code)</i> 21218
ore,	ges 1 and of Health If item 27 or other tr			20b. Place of Dispo cemetery, crer	sition (Name of matory or other pla	сө)	Date	20c. Location - City	or Town, State
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	HILLTOP S				TOWSO ON & BROS	
Ba	Depa Impo any ir		· Edward C. Ruma						, MD 21208
l	15		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final	e death. Do not ent	A 197	22.4		est,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a  Due to (or as a c	onsequence of	Arter	4 012	Lage		
	Examiner	į.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a c	onsequence of):	-				
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events c.						
3760,	ate be executed hysician and the burial-transit	ical Ex	resulting in death) Last Due to (or as a c	onsequence of);					
3	rtificate ng phys as the		d.						
Вох	death certifical e attending phy od for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 (4 Pregnant at time)	Fetal death 3	Ectopic pregnancy Other (specify)	У		23d. Date of Month	delivery Day Year
P.O.	0 0 2	hysid	1 Yes 2 No 9 Unknown	50					
Ś	p o	by	Part II. Other significant conditions contributing to death but n	not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did tob		o to the cause of death?  Probably 4 Unknown
Record	aw requir as been si 2 should	Completed					24a. Was a	24b. Were	autopsy findings available to completion of cause of
a B							perform	ed? death No 1 □ Y	?
f Vital	d. 5	To Be	25. Was case referred to medical examiner?  1 Yes 2 Hospital: 1 Inpatient	2 ER/Outpatien	nt 3 DOA Oth	AC.	ath <i>(Check only of</i> h Home 5☐ Reside	e) nce 6 □Other (S	pecify)
on of	Jing After fune		27. Manner of Death 1 Aural 5 Pending (Month, Day You	ear) 28b. Time of Injury	Wor	y at rk? Yes 2 □No	28d. Describe ho	w infury occurred	
Division	tence eatlest lor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined building, etc. (	- At home, farm, str.		103 2 110	28f. Location (St. City or Town		Rural Route Number,
ō	Hospital or A 24 hours after Funeral Direc tely filled in by								
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of n 2 Medical Examiner: On the basis of exand manner stated	amination and/or inv 1.	vestigation, in my o	pinion, death occ	e, and due to the ca urred at the time, da	ite and place, and d	as stated. due to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier Attending	I Physic	29c. Licens	4		od. Date signed (Mo	,
•	1		30. Name and address of person who opmpleted cause of deat	h (Item 23a) (Type,	Print) ,	6058 Balt	more	MO 21	or 27 2004 218 Versity Pkan
\ <u>                                     </u>	b		Helena o unio 31. Date filed (Month, Day, Year) 32. Registrations	n Ment	rial	Hospit	201	E. Uni	versity Pkay
	Sta Registr		NOV3 Q 2004	per l	a spo	eds!			

			1 - State Of War State Of Registrer	Cer	tificate of I			Reg. No.	04	37635
ı	Physicia		Decedent's Name (First, Middle, Last)     Anne	F	Bischoff		2. Date of Dea	Day Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	THO VEHIC	4c. County		1 10:30 A
		•	3012 Wells Avenue		Edgem			Baltimore Co.		
	Funeral Director		217-50-0638 ¹□м 2 <del>/X</del> F 85	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Sept. 1	h v. Year) .5,1919		place (State or Foreign ntry) gland
	iryland show		,	10c. City, Town or Loc		moro	_,		1	Od. Inside City Limits
	8a-fs	Director	Maryland Baltimore		Edge	er e				1 ☐ Yes 2 PNo
	Nith th	Dire	10e. Street and Number		10f. Zip Code	01010		10g. Citizen of V		
	eath rs 23	erai	3012 Wells Avenue  11. Marital Status 12. Was Decedent Ev	ver in U.S. 13. V	Was Decedent of Hi	21219	ecify Yes or No-	United		can Indian,
	init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland criticnel of Health and Mental Hygiene. Architect of Health and Mental Hygiene. Architect is them 23 a or 28a-f show injury or other traumatic avent. It a Medical Examination to the traumatic avent, It a Medical Examination to the requirement.	by Funeral	Armed Forces?  1 Never Married 2 Married 1 Yes 2 Never Married 2 Married 1 Yes 2 Never Married 1 Yes Grown Year or Dates:		f Yes, specify Cuba I ☐ Yes 2 ☑ No	ispanic Origin? (Spe n, Mexican, Puerto Specify:	Rican, etc.)		k, White, Wh:	
5	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa kind of work done of	ation furing most of worki ')	ng	16b. Kind of Bu	ısiness/ln	dustry
7	within iene. then	dwo	Elementary/Secondary (0-12) College (1-4or 5+)	}	Waitress	,		Clu	ıb/Re	staurant
2	a filed Il Hyg other	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,	Maiden Suman	10)	
a	2 should be filed with and Mental Hygiene is marked other the aumatic event, Ite	To B	Robert Chambers			Mary Jar	ne Hall			
, Mai	1 and 2 sho Health and I em 27 is ma ther trauma		19a. Informant's Name/Relationship (Type, Print) Son  Mr. George H. Bischoff, II	3012	Wells Av	and Number or Rura re. Edgen				
ם ס	Pages 1 and of He nort of He nort of He nort of the north or or other north or other north or or other north or or other north or other north or other north or other north or other north or other north or other north or other north or other north or other north orth orth orth orth orth orth orth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	20b. Place of Dispos cemetery, crem Baltimore			004	20c. Location - Baltin	-	own, State Maryland
	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licensee	Du-	. Name and Addres da-Ruck I	ss of Facility Funeral Ho	ome of	Dundalk	Inc	•
R			23a. Part1. Enter the elease, or complications that caused the shock, or heart in lure. List only one cause on each line.	ne death. Do not ente	22 Wise A er the mode of dyin	AVE DUNG g, such as cardiac o	r respiratory ar	aryland rest,	2122	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a condition resulting in death)	consequence of):	huna		9,-		- 1	MUÑS.
	Examiner		Sequentially list conditions, b. Athero	salevoti	i Curdi	Juana	~ DIS	sauce		20412
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	consequence of j.						
ĵ	an and rial-tra		that initiated events c.	consequence of):						
,00,00	tificate be executed ig physician and as the burial-transit	ledical	d.							
O. DOA .	e death cer the attendin sed for use	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown						23d. Date of delivery Month Day Year	
	uires that th signed by a ld be detach	by	Part II. Other significant conditions contributing to death but	not resulting in the un	nderlying cause give	en in Part I.	23e. Did to	1.1		ne cause of death?
	The law requir cate has been si page 2 should	Completed					24a. Was a autop perfor	sy p med? c	rior to cor leath?	psy findings available impletion of cause of
la l	iclan: The certificate rector, pag	Be C	25. Was case referred to medical			26. Place of Death				
>	Physiclan: this certific al director,	Tof	examiner? 1  Yes 2 No Hospital: 1 Inpatient			4   Nursing Hor	-			y)
	nding Ph th. r: After th e funeral	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day )	Year) 28b. Time of Injury	28c. Injury Work M 1 []	rat k? Yes 2 □ No	28d. Describe h	ow injury occurr	ed	
2 2	To the Hospital or Attending Physician: with 24 hours after death. To the Funeral Director. After this certification pletely filled in by the funeral director,	ertification:	a Could not be	y - At home, farm, stre (Specify)	eet, factory, office	2	28f. Location (S City or Tow	treet and Numb n, State)	er or Rura	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of examiner: On the basis of example and manner state	xamination and/or inv						
	To th within To th compl	Me	29b. Signature and title of certifier		29c. License		2	29d. Date signed	(Month,	Day, Year)
			Kneet Day		1739	leleo	J	went	ser z	2,2004
	1		30. Name and address of person who completed cause of deal Robert Durt 7500	Loren A	Print)	. Presti	maxe	ms	212	-19
	Sta Registr		31. Date filed (Month, Day Year) 3 0 2004 Registration	Signature	& Spo	rely :				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien?

			For State Registrar	state of Ma			nent of n icate of L		Mental my	Reg. No.		3/030
			Decedent's Name (First, Middle, Last)						2. Date of De			3. Time of Death
	Physicia /Medic		Charles					indine	11	20		
	Examin		4a. Facility Name (If not institution, give str			46	4b. City, Town, or Location of Death  Baltimore City  4c. County of Death  N/A					ath
1	a,		Johns Hopkin			16	Under 1 Year	If Under 24 Hr		-		(O) A
	Funeral Director		210 24 0,51	7. Age 7.4	(In yrs. last bir		onths Days	Hours Mir		ay, Year) L2,19	30 M	inthplace (State or Foreign Country) aryland
	and w		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Location	on					10d. Inside City Limits
	Maryli f sho	ō	Maryland Balti	more				Dun	dalk			1 ☐ Yes 2 🛱 No
	the 28a-	Director	Maryland Balti  10e. Street and Number	more		1	Of. Zip Code	Dui	IGGIN	10g. Cit	izen of What C	Country?
	death with the Maryland rms 23s or 28s-f show rmust be notified at		2231 Searles Road					21222		Uni	ted St	ates
	death	Funerai	11. Marital Status	. Was Decedent E	ver in U.S.	13. Was	Decedent of Hi	spanic Origin? (	Specify Yes or Norto Rican, etc.)	0-	14. Race - Am Black, Wh	
9500-61212	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural", or Items 23a or 28a-1 show event, Ita Medical Expressional be notified at	by	1 Never Married 28 Married 3 Widowed 4 Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates:			Yes 2⊠ No		no moan, ero.)		Specific	White
Ş	2 hou	ted	15. Decedent's Educa (Specify only highest grade	tion	16a.	Decedent'	s Usual Occupa	ition luring most of w	odrina	16b. K	ind of Busines	s/Industry
2	filed within 72 Hygiene. pther then "nei ent, I'm Medic	npie	Elementary/Secondary (0-12)	College (1-4or 5+	)			)	orking			-
	Hygien Hygien Ither th	Be Completed		Years		Disp	atcher	40.14-4-1.11			Railro	ad
פת			17. Father's Name (First, Middle, Last) Frederick Hall Bur	rkindino					ame <i>(First, Middle</i> berta He			
Maryland	2 should be and Mental is marked o	2	19a. Informant's Name/Relationship (Type		19h	Mailing A	ddress /Street a		Rural Route Numb			Zin Code)
	DENE		Mrs. Rosemarie Burk		ife 22	31 Se	arles I	Road Du	ındalk, N	Maryl	and 2	1222
Baitimore,	permit. Pages 1 and Department of Heall Important: If item 2 any injury or other once.		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Rei  4 ☐ Donation 5 ☐ Other (Specify)	moval from State	20b. Place of cemeter Hillto	Disposition, cremato  Disposition  Dispositi	n (Name of ry or other place CVice Co	orp. 11/	Date /30/2004		scation - City o	or Town, State aryland
	nit. P vartme ortan injur		21. Signature of Funeral Service Licenses						. Home of	F Daar	d-116	Tng
ă	Der Tag		Manage -						undalk,			21222
E			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	tions that caused t	he death. Do r							Approximate Interval Between
	Physician	110	Immediate Cause (Final disease or condition	Proun							Onset and Death	
	/Medical		resulting in death)	Due to (or as a		of):						TO days
	Examiner		Sequentially list conditions, b.	0								
	be sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events c.	of):								
	xecut and	Examiner	that initieted events c. resulting in death) Last	Due to (or as a	consequence	of):						
68/60,	icate be executed physician and s the burial-transit	edicai E	<b>U</b> d.									
	tificat ig phy as th											
X P P	eath certi attending I for use a	an/N	23b. was decedent pregnant	c. If yes, outcome o		3 □Ect	opic pregnancy				23d. Date of d	,
	ie deal	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at t 9☐ Unknown			ner (specify)				Month	Day Year
J.	hat th od by detach	Phy	Part II. Dther significant conditions conti	buting to death but	not resulting in	the under	Ning cause give	en in Part I	23e. Did	tobacco i	use contribute	to the cause of death?
Division of Vital Records,	The law requires that the death certificate be executed attending physician and attending physician and bage 2 should be detached for use as the burial-transit	Completed by	CHE, COPD, Pulmar		_		,,,,,g			/		Probably 4 Unknown
ပ္ပ	s bee	piete		/					24a. Was		24b. Were a	autopsy findings available completion of cause of
H	Physician: The lav this certificate has al director, page 2	mo								ormed? 2 No	death?	es 2 No
<u>E</u>		Be C	25. Was case referred to medical examiner?					26. Place of De	eath (Check only			
<u>&gt;</u>	hysic his ce Il dire	T <sub>0</sub>	1 Yes 2 No	spital: 1. Inpatien			DOA Othe	ar: 4 Nursing	Home 5□ Res			ecity)
Ē	ing P		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. 1	Time of njury	28c. Injury Work	(?	28d. Describe	how inju	y occurred	
210	tend death for: /	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injur	At home to			Yes 2 No	29f Location	(Stroot an	d Number or 6	Rural Route Number,
	il or Attending Patter death. Director: After t	Certification:	4 Homicide determined	building, etc.	(Specify)	imi, street,	ractory, office			wn. State		nulai noule ivuilibei,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying Physi (Check only one)	cian: To the best of or: On the basis of and manner stat	examination an	e, death oc	curred at the tim gation, in my op	ne, date and place pinion, death occ	ce, and due to the curred at the time	cause(s)	and manner a I place, and du	as stated. ue to the cause(s)
	o the o the smple	Mec	29b. Signature and title of certifier	and manner stat			29c. License	number		29d. Da	te signed (Mor	nth, Day, Year)
	⊢ 3 ⊢ ŏ		1	MO			TY	141		11	124/0	4
	1241		30. Name and address of person who com	pleted cause of de	ath (Item 23a)	(Type, Prin	t)	1 11			,	
	10			MO _	600 V	Nolfe	Stact	5	ohns He	pkin	S Hwp	nital .
gt.	Sta Registi		31. Date filed (Month, Day, Year) NOV 3 0 200	32. Registra	's Signature	6	Sport	20				

			For State Registrar	State	of Maryla	nd / Depa <i>Cea</i>	artment of rtificate of	Health and f <i>Death</i>		gien <b>e</b> () ( Reg. No.	) կ	37637
П			1. Decedent's Name (First, Middle	, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
п	Physicia /Medic		Leon E. Croft	Jr.					Nov.	_	004	7:30 <sup>P м</sup>
п	Examin		4a. Facility Name (If not institution				4b. City, Town,	or Location of De	eath	4c. County	of Death	
			6221 Old Wash 5. Social Security Number	ington R		. last birthday)	Elkr:		rs. 8. Date of Birt	Howai		place (State or Foreign
	Funeral Director		218-18-7566	1 <del>√</del> 2 M 2□F	7. Age (111 )13		Months Day		lin. (Month, Da	y, Year)	Cou	intry)
		ŀ	Usual Residence of Decedent						SEP. 17	, 1925 _		ryland
	how how		10a. State 10b. County	1		ity, Town or Lo						10d. Inside City Limits
	в Ма	cto	MD Howa	.ra	E.	lkridge						1 ☐ Yes 21 No
	dith th	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of \	Nhat Cou	ntry?
	s 238	rai	6221 Old Was		ROad	10 12	21075	Uispanio Origin?	(Specify Yes or No-	USA	o - Ameri	can Indian,
_	hours after death with the Maryland turel', or Items 23s or 28s-1 show I Exscript at the motified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Marr	Armed 8	Forces?	J.S. 15.	If Yes, specify Cu	iban, Mexican, Pu	uerto Rican, etc.)		ck, White,	
200	urs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, C Year or	; 2 □ No Give Dates: <b>Na</b>	vy	1□Yes 2⊋N	o Specify:		Specify	<sup>v:</sup> whit	се
2	72 ho	Completed	15. Deceden (Specify only highs	t's Education	d)	(Give	dent's Usual Occ	e during most of	working	16b. Kind of B	usiness/Ir	ndustry
2	ithin ne.	mpie	Elementary/Secondary (0-12)	T	(1-4or 5+)	life.	DO NOT use reti	red)				
2	lled w lygier her ti		12 17. Father's Name (First, Middle,	( act)			Plumber	18 Mother's I	Name (First, Middle,	Plumb		
and	should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other then "neturel", or Items 23a or 28a-f ehow imatic event, it a Medical Examinatinat be notified at	Be c	Leon E. Croft						erite Arm		,0,	
Maryland 21215-0036	s 1 and 2 should f Health and Men item 27 is marke other traumatic	ဥ	19a. Informant's Name/Relations			19b. Maili	ng Address (Stre		Rural Route Numbe		State, Zij	p Code)
	nd 2		Helen Croft -	wife		6221	Old Was	shington	Road, Ell	cridge,	MD	21075
altimore,	es 1 and 2 of Health fitem 27 r other tra		20a. Method of Disposition	a C.C.	20b.	Place of Dispo	sition (Name of matory or other p	lace)	Date	20c. Location -	City or T	own, State
Ē	Pages nent of ant: if it		1 XBurial 2 ☐ Cremation  1 4 ☐ Donation 5 ☐ Other (S		II State		tine's (	- 1	2/2/2004	Elkrid	e, M	D
ä	permit. Pages Department of importent: if i eny injury or constitute of the constitu		21. Signature of Funeral Service	Licensee		The second secon	2. Name and Add		momal Han	as GMas a		and MD. Ima
m —	80 = 98		MIL	recur	ام	72	50 Wash:	ington B	lvd., Elr	cidge, N	D 2	dge MP, Inc.
П			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	t caused the dea each line.	ath. Do not en	ter the mode of d	ying, such as care	diac or respiratory ar	rest,		Approximate Interval Between Onset and Death
4	Pnysician		Immediate Cause (Final disease or condition resulting in death)	_ a M	tike							weeks
F	/Medical Examiner		resulting in double)	Due to	o (or as a conse	quence of):						i sen :
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	uted d ansit	Examiner	Cause (Disease or injury that initiated events	<b>S</b> .								
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	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Uni	gnant at time of mown	death 5L	Other (specify)					
P.0	res that the igned by be detact	/ Ph	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	nderlying cause	given in Part I.	23e. Did to	obacco use cont	ribute to t	the cause of death?
Sp	uires sign ld be	d by	Distotes mu	lity					_ 101	∕es 2 No	3 🗌 Prof	bably 4 ⊡Unknown
Records,	w requires been si	Completed							24a. Was	an 24b.	Were auto	opsy findings available
	The la te has age 2	omp							autop perfo 1 ☐ Yes	rmed?	prior to co death? 1 🗀 Yes	ompletion of cause of
ta	sicien: The law scertificate has t lirector, page 2 s	Be C	25. Was case referred to medica	I				26. Place of	Death (Check only o			2510
<b>&gt;</b>	Physici this ce al direc	ToE	examiner? 1 ☐ Yes 2 🔼 No	Hospital: 1 [	Inpatient 2	☐ ER/Outpatie	IL 3 DOA	The second second	ig Home 5 ☑ Resid	dence 6 □Oth	er (Speci	fy)
Division of Vital	Attending Physicien: or death. sector: After this certifica by the funeral director, I	on;	27. Manner of Death 1 ☑Natural 5 ☐ Pendir		te of Injury onth, Day Year)	28b. Time of Injury	W		28d. Describe h	now injury occur	red	
Sio	tendi leath. tor: A the fu	cati	2 Accident investi	gation not be				Yes 2 No	20f Leasting //	2444 of \$1	ar or Dur	To the state of th
$\leq$	or Attendation of Director:	Certification;	4 Homicide determ	ined 200. Fla	ding, etc. (Spec	nome, tarm, st eily)	reet, factory, offic	Ө	City or Tox		er or nare	al Route Number,
_	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeret Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 12 Certifyii	ng Physician: To t	he best of my kr	nowledge, deat	h occurred at the	time, date and of	ace, and due to the	cause(s) and ma	anner as s	stated.
	e Hos 24 h e Fur letely	Medicai		Examiner: On the					ccurred at the time,			
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	. 1		Valler K.	Sam	CA		D	2478	/	11/20	1/0	4
	1/11		30. Name and address of person	who completed ca	use of death (Ite	em 23a) (Турв,	Print)	) . / . /	11/	ale in	4. =	
	उ		CHARLES	1. OR	HHAM		00/ 1	INE 1	46-12 A	ve - b	ALTO	in D 21239
	Sta Registi		31. Date filed (Month, Day Year,	2004	Registrar's Sign		1					
	<b>J</b>					1	Ana.					

		•	For Stata Registrar	State of M	arytariu i	•	irtment of F tificate of				ag. No.	004	37638
			1. Decedent's Name (First, Middle, Las	t)					2	Date of Dear	th Day	Year	3. Time of Death
	Physicia /Medic		James CRAL	UFORD						NOV	24	2004	320 PM
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, o					ounty of Death	
			5. Social Security Number 6. So	MY GENE	RAL HO		If Under 1 Year	O L U		. Date of Birth		HOWM	
	Funeral Director			<b>X</b> M 2□F	81	Yrs.	Months Days	Hours	Min.	(Month, Day Dec 12	, Year)	22 West	place (State or Foreign intry) t Virginia
	ס		Usual Residence of Decedent										
	anylan show	<u>.</u>	10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	28a-1	ecto	MD Howard  10e. Street and Number		Gler	boown	10f. Zip Code			1	On Citize	en of What Cou	
	with t	Funeral Director	3700 Championship	Drivo			2173	ρ		1.		ted Sta	
	na 23	era	11. Marital Status	12. Was Decedent		13. \	Was Decedent of H	lispanic Or	igin? (Speci	fy Yes or No-		I. Race - Ameri	ican Indian,
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Medical Event and must be indiffied at once.	/ Fun	1 Never Married	Armed Forces: 1∑Yes 2☐ If Yes, Give	No		fYes, specify Cub 1 ☐ Yes 212 No	an, Mexica Specify:		can, etc.)	5	Black, White	
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br	e filed Il Hyg other vent,	BeC	17. Father's Name (First, Middle, Last)		,			18. Moth	er's Name (i	First, Middle,	Maiden S	umame)	
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Maryland 21215-0036	12 sho h and 7 Is m traum	1 3	Joan Crawford/Wife	**			ng Address (Street Champion						
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nor	ages ant of it: If it y or o		1 Burial 2 Cremation 3 □ '4 Donation 5 Other (Specify		a		natory or other pla le Vet.		11-29-	-2004	Crow	msville	e. MD
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of Vital Records, P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification; To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as of the completed cause of Diagrams and manners of the completed cause of Diagrams and manners of the completed cause of Diagrams and manners of the completed cause of Diagrams and manners of the completed cause of Diagrams and manners of the completed cause of Diagrams and manners of the completed cause of Diagrams and manners of the completed cause of Diagrams and manners of the completed cause of Diagrams and manners of the completed cause of Diagrams and manners of the completed cause of Diagrams and manners of the completed cause of Diagrams and manners of the completed cause of Diagrams and manners of the completed cause of Diagrams and manners of the completed cause of Diagrams and manners of the completed cause of the completed cause of the complete cause of the cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the comp	s a consequer  ong PS: s a consequer  ong PS:	on 'conce of):  y y y y y y y y y y y y y y y y y y	Ectopic pregnance Other (specify)  Inderlying cause give  at 3 DOA  28c. Inju Wo M 1 eet, factory, office In occurred at the ti vestigation, in my office  29c. Licens V 4	y 26. Place and a second of the second of th	I.  e of Death ( ursing Home 28 ]No 28  and place, an ath occurred	23a. Did to  1 Yes  24a. Was a autops perform 1 Yes  Check only or a 5 Residud. Describe horizon (S. City or Town)  d due to the color at the time, d	bacco using the symmetric	Month  e contribute to  No 3 Pro  24b. Were aut prior to codeath?  1 Yes  Other (Special Cocurred)  Number or Run  and manner as a slace, and due is signed (Month).	the cause of death? the cause of death? that cause of death? that cause of death? that cause of death? that cause of death? to how the cause of death? to the cause of death? to the cause of death? to the cause of death? to the cause of death? to D 4

State of Maryland / Department of Health and Mental Hygiens 004 37639 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Da **Physician** 23 CHRISTOPHER BRUCE CARLAW 2004 10:20% /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death 4c. County of Death Examiner National Institute of Health Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□ F Months Days Hours Yrs. 54 1950 Director 140-40-5402 New Jersey Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f ahow the Medical Examiner reast be rediffed at 1 ☐ Yes 2 🖾 No Maryland Montgomery Bethesda Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8705 Jefferson St. 20817 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 20 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Developement / Elementary/Secondary (0-12) College (1-4or 5+) V.P. Senior Development Dir. Real Estate other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permir. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event page. Theodora James Carlaw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gaye Brown / Wife 8705 Jefferson St., Bethesda, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ' 4 ☐ Donation 3 ☐ Other (Specify) Chesapeake Crematory 11/29/04 Beltsville, MD 21. Signature of Fundral Service Latensee 22. Name and Address of Facility Rapp Funeral and Cremation Services Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20910 933 Gist Ave., Silver Spring, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) isme manore failure + Sepsis Physician week /Medical Due to (or as a consequence of): home dragocytic Syndrom Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Physician/Medical as the the attending property the design of the des 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No has certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA To the Hospitel or Attending Phys within 24 hours after death.

To the Funerat Director: After this a completely filled in by the funerat dir this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27, Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 24104 D0061532 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WEEREN 10 CENTER DRIVE, BETHESDA, 20892 Daniel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 3 0 2004 Registrar

amend item#14, perFil, 6842, 4-11-05 TT State of Maryland / Department of Health and Mental Hygiens O. I. 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 20<u>04</u> Month **Physician** 15, Nov. Conner 1:14 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
July 11, 1951 7. Age (In yrs. last birthday, 53 Yrs. Birthplace (State or Foreign
Country) 5. Social Security Number Funeral 1 □ M 2 🛣 F 577-70-3993 unobtainable Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other then "neturel", or items 23s or 28e-1 show other treumatic event, the Medical Examinar must be notified at 1 NYes 2 No MD Montgomery Silver Spring Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number With United States 401 Hungerford Dr. 20852 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status UNK Black, White etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Importent: if tiem 27 is marked rother then "naturel", or tier any injury or other treumatic event. 2 Married ☐Yes 2☐No Yes, Give 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 2 white 4 Divorced 3 Widowed Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) unobtainable unobtainable 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be unobtainable unobtainable ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Suzanne Lord, Guardian of Pers. 401 Hungerford Drive, Rockville, MD Rep. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/30/04 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Lio 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Avenue Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Sepsis /Medical Due to (or as a consequence of): **Examiner** Myocardial Infraction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐XNo 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; After 1 1 X Natural 2 Accident 5 ☐ Pending investigation after death. 1 Tyes 2 □ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 060826 shama 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Dr. K.F. Wang

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 3 0 2004

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of			giene	2761.1
I	Physici	an	1. Decedent's Name (First, Middle, Last Lillian I. (	·				2. Date of Dea		3. Time of Death 8:45а м
	/Medic Examin	al	4a. Facility Name (If not institution, give Renaissance Gard	street and number)			r Location of Death tonsville		4c. County of De	
	Funeral Director		211 10 3100	x 7. Ag	e (In yrs. last birthda) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Oa)	(, Year)	irthplace (State or Foreign Country) [aryland
	yland now		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Ba-fsh	ector	Maryland Baltin	nore		Catonsvi	lle			1 ☐ Yes 2 XNo
	n with th	ai Dir	10e. Street and Number 707 Maiden Choice	Lane Apt.	. 3409	10f. Zip Code 212.	28		10g. Citizen of What 0 USA	Jountry?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It item 27 is marked other than "natural", or Items 23e or 28e-f show or other treumatic event, the Medical Example must be maillised at	by Funeral Director	11. Marital Status  1    Narried 2   Married 3   Widowed 4   Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, lite, etc. White
21215-0036	ithin 72 hou nan "natura nan "natura nadical E	Completed	15. Decedent's Edi (Specify only highest grad	ucation le completed) College (1-4or 5	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	during most of work	ing	16b. Kind of Busines	
d 21	e filed wall Hygier other the		12 17. Father's Name (First, Middle, Last)		S	upervisor	18. Mother's Name	e (First, Middle,	Librar Maiden Surname)	У
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Maryland	d 2 should the and the and the treum treum		19a. Informant's Name/Relationship (T) Bryan Frederick Ga						r, City or Town, State, Ott City,	
	es 1 and of Health fitem 27 r other tr		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ f		20b. Place of Disp	and the second second	! !	Date	20c. Location - City of	
Baltimore,	t. Pa ntmer rtent: njury		*4 □ Donation *5 □ Other (Specify,			ematory,			Baltimor	
Ba	permi Depa Impo eny ir		Jumpa	MALM Donald	alch	Cremation 299 Frede	Society rick Road	of Mar Balti	yland, Inc	1228
8760,	/Medical Examiner	dical Examiner	shock, or heart failure. List only of disease or condition resulting in death)  Sequentially list conditions, Tany, leading to arresulting cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):	diseo	rse_			Interval Between Onset and Death
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ds, P	es De	by	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did to		to the cause of death?
of Vital Record	e law has b	Completed						24a. Whas a autop: perfor	sy prior to med? death?	autopsy findings available completion of cause of
Vita	icien: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death	h (Check only or	ne)	
	ng tter	ation: To	1 Yes 2 7 Wo  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	rv 28b. Time	of 28c. Injur	4 Nursing Ho		ence 6 □Other (Sp ow injury occurred	ecify)
Division	그 를 들 ㄷ	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Flace of Inj	ury - At home, farm, s c. <i>(Specify)</i>	street, factory, office		28f. Location (S City or Tow	treet and Number or f n, State)	Rural Route Number,
	Hospitel (24 hours at Funerel Detely filled i	edical	29a. Certifier  (Check only one)  1 Certifying Phy 2 Medical Exam	rsician: To the best iner: On the basis of and manner sta	f examination and/or	ath occurred at the tir investigation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, c	ause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mor	
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	1 /		30. Name and address of person who of Den ven Bowlin M	O 7//	maiden (	Choice	Lane, Co	tensvil	11/26/ (le, mo	21228
1	Sta Regist		31. Date filed (Month, Day, Year) WOV 3 (	2004 32. Registr	ar's Signature	& Spo	uls "		,	

Amend Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O. 1. 37642 For State
Registramend item 326 per fh g837
Decedent's Namey (First, Middle, Last)

Registramend item 326 per fh g837
Registramend item 326 per fh g837
Registramend item 326 per fh g837
Registramend item 326 per fh g837 Reg. No. 2. Date of Death 11/08/2004<sup>3</sup>. Time of Death ? Physician MOND NOV 4,00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DAL MOKE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) last birthday) **Funeral** Months 20-033 1 M 2□ F Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö EKK 238 Was Decedent Ever in U.S. Armed orces? 1 Dres 2 □ No or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: WW 1 Yes 2 No Specify: Completed by "natural", Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) marked other than College (1-4or 5+) Hygiene. 12 disabled disabled peli 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mental H Be 19a. Informant's Name/Relationship (Type, PMS, Luchs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition 20a. Nethod of Disposition 20c. Location -Pages 1 permit. Pages 'Department of H Important: If Ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2004 21. Signature Trup ral Service License once. 21221 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such Immediate Cause (Final disease or condition ENDSTAGE **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit POXIA certificate be executed and Due to (or as a consequence of): 68760 the attending physician Physician/Medical Box ( IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant death ( 1 ☐ Live birth 2 ☐ Fetel death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ò in the past 12 months? Dav Year 5 Other (specify) P.0. ☐Yes 2☐No detached 9 Unknown 9 Ulnknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has autopsy performed? 2 KNo Physicien: funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA thursing Home 5 Residence 6 ther (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: To the Hospitel or Attending I within 24 hours after death.
To the Funerel Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 100 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ite salla 0041202 30. Name and address of person who completed cause of death (Item 23a) (Type 31. Date filed (Mo 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie () [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 25, 2004 **Physician CULBERTSON** DAWN CHRISTINE 11:15P № /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Northwest Hospital Center Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
August 17, 1951 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M Maryland Yrs. 217-60-1744 53 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. Count r then "neturel", or Items 23a or 28e-f show the Medical Examinational be notified at 1xXYes 2 No Directo Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 USA 2831 Guilford Avenue Apt 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ĀM No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. XX Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Musician/Writer Free Lance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other traumatic event once. Donald Nathaniel Culbertson Ruth Elizabeth Snell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6738 Glen Kirk Road Baltimore, Maryland 21239 19a. Informant's Name/Relationship (Type, Print) Ruth E Culbertson Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/30/04 Greenmount Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service/Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complicate his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arterioscleratic Cardiovascular **Physician** disease or condition resulting in death) LOYRATS /Medical Examiner 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events physician and resulting in death) Last Due to (or as a consequence of): by Physician/Medical the use as attending IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XNo 9 ☐ Unknown be detached Division of Vital Records, P.O. the 9 Unknown ned by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an page 2 2 XNo 1 Yes or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death the 1 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Hospitel 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 01866 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CT. Lutherville, Marylan litello, ND Trimb 32. Registrar's Signature State NOV3 0 2004

DHMH 17 Rev 1/2001

Registrar

4b City Town or Location of Death

Bethesda

8:21a<sup>™</sup>

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Dav

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dav. Year)

White

1 Yes 2 □ No

4c. County of Death

Montgomery

**Funeral** Director

**Physician** 

/Medical

Examiner

Director

Funeral

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Be

Examiner

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Completed

Certification; To

27. Manner of Death

1 Naturai

2 Accident

3 🗌 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signature and title of certifier

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

the Maryland 28a-f show other traumatic event, the Medical Examinar must be notified at 6 Items 23a death 72 hours after 6 "natural" 1.2 should be filed within 7.2 h and Menta! Hygiene." 7 Is marked other than "na permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun once.

Saltimore, Maryland 21215-0036

Physician /Medical **Examiner** 

use as the burial-transit attending physician and

Hospital or Attending Physician: Director within 24 hours a To the Funeral E

If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 414-68-0381 1**⊠**M 2□F Months Days Hours Min. 77 Yrs 1⁄927 Ĭ'nďiana Usual Residence of Decedent 10c City Town or Location 10b. County 10a State HARRIS Galveston Seabrook Texas 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 77586 427 Biscayne Blvd. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Aerospace 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Vera Seed Myron L.Curtner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Curtner/Wife 427 Biscayne Blvd. Seabrook, Texas 77586 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Fairview Cemetery 11/30/04 Vincennes, Indiana 4 □ Donation 5 Other (Specify) 21. Signatura di Ineral Service Licyns e PHILIP D.RINALDI FUNERAL SERVICE, P 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CHRONIC OBSTRUCTIVE PULMONARY disease or condition resulting in death) CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA

State Registrar

Truong Bao MD. 31. Date filed (Month, D

5 Pending investigation

6 Could not be

determined

32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004



28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

D0057124

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

un os

State of Maryland / Department of Health and Mental Hygiene For State Registrar 004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 6:30р м **Physician** Nov. 19, 2004 Curtin Joyce Ann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8528 Blunts Lane Fulton Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6 / 20 / 1940 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 20 F 64 579-52-6930 Wash., D.C. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examination confiled at 90cg. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2X No Director Howard Fulton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8528 Blunts Lane 20759 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White δ 3 ☐ Widowed 4 反 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coffege (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Ernest Bettis Nan Lorena Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Connie Gibson/Daughter 8528 Blunts Lane Fulton, MD. 20789 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Remoyal from State Ft.Lincoln Cem. 11/23/04 Brentwood, Md 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 114. 9241 COLUMDIA BLVd.S1LV
23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart if ure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years organism summing CHRONIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exan iner burial-trarisit The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: 23c. ff yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetaf death jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by pe 3 ☐ Probably 4 ☐ Unknown 184 Yes 2 □ No been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No has page 2 certificate 1 ☐ Yes 2 ☐ No Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 | Impatient | 2 | ER/Outpatient | 3 | DOA Other: 4 ☐ Nursing Home 5 ☐ esidence 6 ☐ Other (Specify) 1 Yes 2 No ဥ this completely filled in by the tuneral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Director: Atter fnjury 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral I 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1005mstr 13, 2004 1125944 30. Name and address of pers who completed cause of death (Item 23a) (Type, Print) 5540 Ten Oaks Road Clarksville, MD 21029 Evelyn Jackson MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV3 0 2004 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#12.perFH.G837.11/30/04 TT

			1- State of Maryland / Dep Registrar Ce	artment of Health and Mental Hy rtificate of Death	giene 2004 37646
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of De Month	Day Year
	/Medic		ELWOOD DENNIS	NOVEMB	ER 25, 2004 5:30 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			3629 VALLEY TERRACE #5 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	RANDALLSTOWN  If Under 1 Year If Under 24 Hrs. 8. Date of Bir	BALTIMORE
	Funeral Director		215-20-1144 **XXM 2   F   79   Yrs.	Months Days Hours Min. (Month, Da JULY 2	y, Year) Country)
			Usual Residence of Decedent		, 1925 AD
	uylan show	_	10a. State 10b. County 10c. City, Town or I	ocation	10d. Inside City Limits
	8a-f s	cto	MD BALTIMORE RANDALLI		1 X Yes 2 No
	vith th	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	s 23s	eral	3629 VALLEY TERRACE #5  11. Marital Status 12. Was Decedent Ever in U.S. 13	Was December of Hispania Origina (Specify Vos or No	USA  14. Race - American Indian,
	ther de	<b>Funeral Director</b>	Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
036	urs al	by	1 □ Never Married 2 □ Married 1 □ Tres 2 □ No lf Yes, Give 1 Yes, Give Year or Dates: 1944-46	1 ☐ Yes 2 🟋 No Specify:	Specify: BLACK
215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. dother than "natural", or items 23a or 28a-f show event, tre Madical Evertine must be rutified at	Completed	15 Decedent's Education 16a Dec	dent's Usual Occupation	16b. Kind of Business/Industry
2	within iene. then "	nple.	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)	
121	filed withi Hygiene. othar than ant, Ire M		12 IF	ON WORKER  18. Mother's Name (First, Middle	BETHLEHEM STEEL
Maryland	ould be fi Mental H tarked ot tatic eval	Be	ERWIN DENNIS	BEATRICE	Maiden Sumame)
Z	# DEE	2		ing Address (Street and Number or Rural Route Numb	er, City or Town, State, Zip Code)
Z	and 2 s ealth ar n 27 ls nar trau			HAMMERSHIRE ROAD OWINGS	
altimore,	s 1 and 3 of Health item 27 other tra		20a, Method of Disposition 20b. Place of Disposition	osition (Name of Date matory or other place)	20c. Location - City or Town, State
E	Page tent o int: If		1 X Burial 2 Cremation 3 Hemoval from State	ORIAL PARK 12-1-2004	BALTIMORE, MARYLAND
alti	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signatur of Funeral Service Licensee	2. Name and Address of Facility $JAMES  A$ . $ $	
<u> </u>	89 5 8 9		James W. Morton		TIMORE, MARYLAND 21217
			23a. Part / Enter the disease, or complications that caused the death. Do not en speck, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory a	rrest, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	state concer	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):		
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
oʻ	e be executed rsician and e burial-transit	Exa	resulting in death) Last  Due to (or as a consequence of):		
68760,	ficate be executed physician and is the burial-transit	edical			
	artifica ing pt e as t	Med	IF FEMALE:		
Box	eath certiff attending I for use as	ian/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy	23d. Date of delivery  Month Day Year
	the de	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Other (specify)	
P.0	Physician: The law requires that the death certi this certificate has been signed by the attending ral director, page 2 should be detached for use a		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did t	obacco use contribute to the cause of death?
Records,	uires n sign lid be	d by		1 🗆	Yes 2 No 3 Probably 4 Unknown
8	aw requiras as been si 2 should b	lete		24a. Was	an 24b. Were autopsy findings available
	The la	Completed			prior to completion of cause of death?  2 1 Yes 2 No
of Vital	ician: Th certificate rector, pag	0	25. Was case referred to medical	26. Place of Death (Check only of	7
)_	hysician: his certific I director,	To B	examiner? 1   Yes   2   No   Hospital: 1   Inpatient   2   ER/Outpatie		dence 6 ☐Other (Specify)
			27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	now injury occurred
Sio	tan eatl or: the	icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	Street and Number or Rural Route Number,
Division	or Attanoafter death	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	City or Tou	vn, State)
-	To the Hospital or Attan within 24 hours after deat To tha Funaral Diractor: completely filled in by the		29a. Certifier Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, and due to the	cause(s) and manner as stated.
	ne Ho 1 24 h na Fu	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at the time,	date and place, and due to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier		29d. Date signed (Month, Day, Year)
)	11		Du ling no	D 40854	11/30/2004
	Xx.		30. Name and address of person who completed cause of death (Item 23a) (Type		21302
	U a		31. Date filed (Month, Day, Year)  32. Registrar's Signature		~ 30L
	Sta Registi		NOV 3 0 2004 Server	Sporks	

State of Maryland / Department of Health and Mental Hygie () [ ] 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 23, 2004 5:42р м **Physician** WILLIAM HENRY DAVIS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1∏M 2□F Months Days Director MARYLAND 213-12-7700 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show itam 27 ia marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Wedical Examinating instituted at 1 ☑ Yes 2 ☐ No Director MD. ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1997 WEST ST. 21401 USA Completed by Funeral should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married ☐Yes 2 Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. Itam 27 ta marked othar than Elementary/Secondary (0-12) College (1-4or 5+) WAREHOUSE FOREMAN FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FREDRICK DAVIS SR. ORA BROWN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: If Itam 27 Ia i ury or other traus GARY DAVIS(SON) 1997 WEST ST. ANNAPOLIS, MARYLAND 21401 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any njury or MARYLAND NATIONAL 11-30-2004 LAUREL, MARYLAND 22. Name and Address of Facility WM. REESE & SONS MORTUARY P.A. 21. Signature of Funeral Service Licensee eeseMc0485 821 WEST ST. ANNAPOLIS, MARYLAND 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical s a consequence of): Examiner VPULLONIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attanding Phyaicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the l use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year ō Month Day 4☐Pregnant at time of death 5 Other (specify) Ö detached 9 Unknown ۵ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 ∐ Yes 2 ⊡ No 3 ⊡ Probably 4 🕽 📶 known director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Tes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Hpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation t Saturai 2 No 2 Accident death after death Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide The critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hc To tha Fun completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 104 completed cause of death (Item 23a) (Type, Print) terer Masnich 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 3 0 2004

**ORIGINAL** 

DHMH 17 Rev 1/2001

				_ State	nd / Department of Health and N Certificate of Death	Mental Hygie	חחל	3761.8
				Registrar  Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. 2. Date of Death	N6:- 0 0 %	3. Time of Death
		Physicia /Medic		VIOLET P. DO	WNER	NOV 1	3 2004	9:20 4
		Examin		a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	F	uneral		Social Security Number 6. Sex 7. Age (In yrs.		8. Date of Birth	9. Birthp	lace (State or Foreign
		irector		N/A 10M 20 F 62	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye MARCH .	1942 JA	MACA
	land	show ed at	-	Jsual Residence of Decedent  Oa. State 10b. County 10c. Ci	ity, Town or Location		1	0d. Inside City Limits
	ө Мал	liffed	ctor	JAMACA N/A	JAMACA			1 ☐ Yes 2 No
	death with the Maryland	a or 28 De no	Director	0e. Street and Number / JAMACA, W.	I 1/2 3 10f. Zip Code	10g.	Citizen of What Cour	ntry?
	death	ms 23	Funeral	1. Marital Status 12. Was Decedent Ever in L	J.S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Americ	an Indian,
	9	or ite	by Fur	Armed Forces?  1 Never Married 2 Married  3 Widowed 4 Divorced  Armed Forces?  1 Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	Hican, etc.)	Black, White,	etc.
	ind 21215-0036 be filed within 72 hours after	"natural", or items 23a or 28a-f edical Examiner must be notific	ted b	15. Decedent's Education	16a. Decedent's Usual Occupation	16b	BLA. Kind of Business/In-	dustry
	1215 ithin 7	nan "nar	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	king	0011	
	d 21 filed w	othar t		7. Father's Name (First, Middle, Last)	ANCILLARY STAF	e (First, Middle, Maid	OCHUCH den Sumame)	
	/lan	rkad c	To Be	UNKUOWN DOWNER	MARYA	IND FER	GUSON	
	Maryland 21215-0036 d2 should be filed within 72 hours after and Marial Hydiene	is me		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number of Run	ral Route Number, Ci	ty or Town, State, Zip	Code) 4D.21704
	⊆ 7	tam 2 othar 1	1			Date 20c	Location - City or To	
٤	0 0	ant: If i		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	cometery, crematory or other place)  NOV.	15 1 B	ALTIMOR	E.ND.
31	Baltimore,	Important: If item 27 is marked other than "natural", or items 23s or 28s-1 shov any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sonature of Funeral Service Licensee	22. Name and Address of Facility	29 HUD	SOUST.	2
9				23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failule. List only one cause on each line.	th. Do not enter the mode of dying, such as cardiac	or respiratory arrest,	E, 140.	Approximate
	Pny	sician i		shock, or heart tailure. List only one cause on each line. Immediate Cause (Final disease or condition	astatio mean	it car	Cer	Interval Between Onset and Death
		edical iminer		resulting in death)  Due to (or as a consecutive control of the co	quence of):			3.100
D			Je.	Sequentially list conditions, fany, leading to immediate Due to (or as a consec	quence of):			
2 6	ecuted	and Il-transit	Examiner	Sequentially list conditions, f any, leading to immediate ause. Enter Underlying Cause (Disease or injury hat initiated events essulting in death) Last				
	60,	ohysician and the burial-transit	at E)	Due to (or as a consecutive of the consecutive of t	quence or):			
-0	<b>છ</b> ∰	as the	Aedical	d.				
الم	Box	attending p	lan/h	FFEMALE:  23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fet	al death 3 □Ectopic pregnancy		23d. Date of delive	ry Day Year
T	o: the de	i signed by the a ld be detached f	Physician/Me	1   Yes 2   No 9   Unknown	death 5 Other (specify)			
W	ords, P.O	gned b	by PI	art II. Other significant conditions contributing to death but not re-	sulting in the underlying cause given in Part I.		co use contribute to the	
	Records,	been si should				-		ably 4 □Unknown
		e has	Completed			24a. Was an autopsy performed	? death?	osy findings available inpletion of cause of
3		certificate has rector, page 2	Be C	25. Was case referred to medical examiner?	26. Place of Deat	1 ☐ Yes 2 12 h (Check only one)	No 1 ☐ Yes	2EN0
A	of Vita Physician:	this co	၉	1 ☐ Yes 2 DN6 Hospital: 1 ☐ Inpatient 2 ☐		ome 5 Residence		Mosmice
+	ion inding	r: After e fune	ation	27. Manner of Beath  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation  28a. Date of Injury (Month, Day Year)	28b. Time of Injury at Work?  M 28c. Injury at Work?  1 Yes 2 No	200. 00001100 11011	nary occurred	
olet	Division of or Attanding	iracto n by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be building, etc.)	nome, farm, street, factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	Route Number,
5	Spitel of	filled i	ai Ce	29a. Certifier 1 20 Certifying Physician: To the best of my kn	owledge, death occurred at the time, date and place,	and due to the cause	e(s) and manner as st	ated.
	Division To the Hospitel or Attending	To tha Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2	ledical	(Check only 2 Medical Examiner: On the basis of examinations) and manner stated.	ation and/or investigation, in my opinion, death occurr	red at the time, date	and place, and due to	the cause(s)
	5 tim	To Cou	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, I	Day, Year)
	7	7		80. Name and address of parson who completed cause of death (Ite.	m 23a) (Type, Print)	Dain	11/1/10	T. (-7)
		J		Juna Hanner 600 31. Date filed (Month, Day, Year) 32. Registrar's Sign	DVI. WOITE ST	Dam	mne	211284
	F #	Sta Registr	1.0	31. Date filed (Month, Day, Year) 0 2004 32. Registrar's Sign	& Sparke			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 700 4 **Physician** 51157M Mary Lucille Dennison ovember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Huspita If Under 1 Year If Under 24 Hrs. 8. Date of いかけ rund 8. Date of Birth (Month, Day, Year 1/21/1928 Birthplace (State or Foreign Country)
 TN 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 2)(C) F 76 Director 412-42-0122 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State in then "naturel", or Items 23s or 28s-f show the Modical Expedient cost to notified at 1 Yes 2 No Millersville Director MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21108 USA 512 Valleywood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filad within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: þ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 permit. Pagas 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other treumetic event 20x8: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Collins Walter Wykle ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pasadena, Maryland 21108 Susan Smith / daughter 8372 Capel Drive, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State Nov. 29, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2004 Glen Burnie, MD Glen Haven 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. MO1357 Tare le 1 Second Ave. SW, Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, en monin Immediate Cause (Final **Physician** One CLAV disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list curvations, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical the as 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 20 No 1 Yes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred Certification: al or Attending F after death. I Director; After After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No М 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide

To the Hospitel o within 24 hours aff To the Funeral Di completely filled in

State Registrar

29a. Certifier

29b. Signature and title of certi

who completed cause of death (Item 23a) (Type, Print) E 32. Registrar's Signature

TEXEcrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated.

miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 37650 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** November 26,2004 14:00 P M Davis /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Balty More City

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. N/A The Johns Hogkins Hospital 8. Date of Birth (Month, Day, Year) 08/25/1933 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K Months 219-28-2334 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or 28a-f show Exacting must be notified at 1 ☐ Yes 2 ☐ No Directo BALTIMORE MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 U.S.A. 8201 MAXINE CIRCLE or Itams 23a Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If item 27 is marked other then "natural", or Item any njury or other traumatic event, the Medical Evantural once. 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CPA ACCOUNTING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HOLZWEIG SODDEN NATHAN IDA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BERNARD DAVIS / HUSBAND 8201 MAXINE CIRCLE BALTIMORE, MD. 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BETH EL MEMORIAL PARK 11/29/2004 RANDALLSTOWN, MD ^ 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service I with 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 5mall **Physician** Cell 1PCV luna resulting in death) /Medical Due to (or as a consequence of): Examiner Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit · Hupercoubic that initiated events and resulting in death) Last to (or as a consequence of) P.O. Box 68760. the attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by be, 1XYes 2 □ No 3 Probably 4 Unknown been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No has this certificate or Attanding Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 10 1 Yes 2 No 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification; After 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the f within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide the Hospital Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) ledical Docter RES -000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimere Maryland Molden North Wolte Victoria 32. Registra s Signature 31. Date filed (Month, Day, Year) State NOV 3 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene

					C	Certific	ate of	Death	,	Reg. No.	) 4 3	1651
	Physici	an	1. Decedent's Name (First, Middle, Last						2. Dete of De Month		Year 3.	Time of Death
Ü.,	/Medic		Joseph Tilgh						Novemb			553 A.
	Examin	er	4e Facility Name (If not institution, give 2807 Fleetwood Ava	enue				Baltim			y of Deeth  /a	
	Funeral Director		2.0 20 0001	7. Age (In	yrs. last birtho 73 Yrs	Mont	der 1 Yeer hs Days	If Under 24 Hr Hours Min		rth ey, Year) , 1931	9. Birthplace Country) Maryla	State or Foreign nd
	end **		Usuel Residence of Decedent  10a. Stete 10b. County	100	. City, Town o	r Location					10d. in	side City Limits
	Mary Fe sh	tor	Maryland n/a		Baltin							(XYes 2□No
	ter death with the Marylen Herns 23a or 28a-f show Inst. must be notified at	I Direc	10e. Street end Number 2807 Fleetwood	Avenue		10f.	Zip Code	21214		_	What Country? States	
020	within 72 hours after death with the Marylend ene. than "natural", or items 23e or 28e-f show fre Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Agned Forces? 1 ∆1 Yes 2 □ No If Yes, Give Year or Detes: KO			V	ispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)		ce - American Inc ck, White, etc.	
5-0	natur dical	etec	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. De	ecedent's U live kind of	sual Occupa work done o	ation during most of w	orking	16b. Kind of E	Business/Industry	
121	be filed within 7 ttal Hygiene. Id other than "n	dm	Elementary/Secondery (0-12)	College (1-4or 5+)	\\	Surve		1)		Sol	f Employ	od
d 2	e filed within the Hygiene.	ပ္	12 yrs.			Jul V	Syon	18. Mother's Na	ame (First, Middle			eu
lan		To Be	Joseph T. Downey,	Sr.				Emma		rphy		
ary	d 2 should th end Men 7 ie merke trsumetic		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. M	lailing Addr	ess (Street a	and Number or F	Rurel Route Numb	er, City or Town	, State, Zip Code	)
Σ.	end 2 ealth n 27 i		Mr. Michael T. Dow					venue C	ambridge	, Maryl	and 216	13
Baltimore, Maryland 21215-0020	Peges 1 en ment of Heal ent: If Item 2 ury or other		20a. Method of Disposition  1 Buriat 2 Oremation 3 F  4 Donation 5 Other (Specify)	temoval from State	illtop	cremetory o	or other plac	•	Dete 11/29/20		- City or Town, S WSON,M[	
Balt	permit. Peges Depertment of important: If if any injury or once.		21. Signature of Funeral Service Licens	™ Michael E. (	Canapp			Ruck,		305 Harf altimore		1214
	100		23e. Pert1. Enter the diseese, or compleshock, or heart failure. List only or	icalions that caused the d	leath. Do not						Appr	oximate val Between
	Physician /Medical Examiner			Cirrhe		. )	the	1 -	n		Onse	at and Death
ox 68760,	The lew requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be deteched for use as the buniel-transit	in/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest		o (or as e con							
. Bo	death	sicia	Part II. Other significant conditions con	tributing to deeth but not	resulting in the	e underlying	cause give	en in Pert I.	23b. Did	tobacco use co	ntribute to the c	ause of death?
, P.O	that the ned by the deteche	y Physician/							1 🗆	0		4 ☐ Unknown
Records, P.O.	lew requires es been sig 2 should b	Completed by							24a. Was perfo	an autopsy rmed?	24b. Were aut available completic of death?	prior to on of cause
<u>س</u>	ician: The lev certificate has rector, page 2	5							110	fes 2LNo	18 Yes	2□ No
Vita Vita	lclan: Sertific Sector,	Be	25. Was case referred to medical examiner?	ospital:			Othe	NP:	ath (Check only o			
ō	Attending Physician: or death. sctor: After this certific by the funeral director,	은	1 XYes 2 No 27. Menner of Death	1 L Inpatient 2	28b. Time			4 Li Nursing i	Home 5 Resident	dence 6 XIOth		scene
0	ding th: After fune	텵	1 Naturel 5 Pending 2 Accident investigation	28e. Date of Injury (Month, Dey Year	) Injur		28c. Injury Work	t?` Yes 2 □ No	200. 2030100	iow injury occur	100	
	i or Atten efter dee Director d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, ecify)	street, fact	ory, office		28f. Location (S City or Tox	Street and Numb vn, Stete)	per or Rural Route	Number,
	To the Hospital or Attending Physician: The lev within 24 hours effer deeth.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my ler: On the basis of exam and manner stated.	nowledge, de ination and/or	ath occurre investigation	ed at the time on, in my op	e, date and place inion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place,	anner as stated. and due to the ca	iuse(s)
	Toth Toth comp		29b. Signature and title of certifier	An	W	2	9c. License	number ME			d (Month, Day, Yer 24, 20	
,	5 <sup>1</sup>		30. Neme and eddress of person who co	to 4 AM			111 P	enn Stre	et, Balt	imore,	Maryland	1 21201
	Stat	e ,	31. Date filed (Month, Day, Year)	32. Registrer's Sig	gnature	9		19				

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiers 37652 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year. **Physician** 7:00 AM Hope EVANS 24 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA BALTIMORE FORTVIEW WAY If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Days 1 ☐ M 2 🛛 F Months 216:34.4220 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, I've Modical Exercities coust be notified at 1 ¥Yes 2 □ No BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6110 FORTVIEW Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ ♣No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK If Yes, Give Year or Dates: Completed by 3 Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) BALTIMORE COOK 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Jarmella Jones, Sr. uther Minnis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21222 Avenue Habird hariene tvans Danghte Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h 1 MBurial 2 ☐ Cremation 3 Removal from State 12.02.04 WOODLAWN, MD WOODLAWN ` 4 □ Donation 5 □ Other (Specify 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICES SEN PALTIMURE NATUPIKE BALTIMURE, MU 21221 21. Signature of Fundial Service Licer 23a. Part1. En ed isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NOUN disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions Due to (or as a consquence f): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque The law requires that the death certificate be exer Box 68760. the attending physician lsus by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 1 No 3 Probably 4 Unknown page 2 should Be Completed 17 Thit 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 12 No 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner?
1 Yes 2 No director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide 24 hours a 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 2 To the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ess of person who completed cause of death (Item 23a) (Type, Print) 2 Sr Paul Pl 31. Date filed (Month 32. Registrar's Signature State Registrar

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-	Funeral		Social Security Number     6. Se	z _	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birthplace (State or Foreign
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	eeth	era	11. Marital Status	12. Was Decedent Ever in		Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe	cify Yes or No-		- American Indian,
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	To the Hospital or Attending is within 24 hours efter death.  To the Funerel Director: Atter completely filled in by the funer	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Example)	ysician: To the best of my iner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the time vestigation, in my opi	e, date and place, a nion, death occurre	nd due to the car d at the time, da	use(s) and mani te and place, an	ner as stated. Indidue to the cause(s)
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			30. Name and address of person who d			Print)				
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygie 20 0 4 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** FLORENCE R. FIELDS November 2:45 PM 27 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** YORTH ARUNDEL HOSPITAL TLEN If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Days 1 □ M 2 1 F Months MARYLAND 219-26-8126 Yrs. 14, Director 67 MAY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location of Health and Mental Hygiene.
itam 27 Ia marked other than \*natural; or Itams 23s or 28s-f show other traumatic avant, the Medical Examinations to inclined at 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo ANNE ARUNDEL GLEN BURNIE MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1605 JENNINGS ROAD 21061 UNITED STATES by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes XX No Specify: Specify 3 ☐ Widowed 4 ☑ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DESK CLERK HOTEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES EDINGER DOROTHY GRENAGLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Department of Health Important: If itam 27 15 LUKE DRIVE PASADENA, MD 21122 MARY RIVERS/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State DEC. 1, 1 X Burial 3 □ Cremation 3 □ Removal from State ö GLEN HAVEN MEM. PK. • 4 □ Denation 5 □ Other (Specify) any injury 2004 GLEN BURNIE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY S.E. CLEN BURNIE, MD 21061 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** o cardial day disease or condition resulting in death) /Medical Due to (or an a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit certificate be executed Due to (or as a consequence of): as the burial Division of Vital Records, P.O. Box 68760 Physician/Medicai attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has 1 Yes 2 3 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this 27. Mann of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: I or Attanding F after death. After 5 Pending investigation 1 🗌 Yes 2 Accident Director: A 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 100 Vovembar 27, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harles & Wiles III MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar NOV 3 0 2004

S, HORENCE

Amend Item 1&UnStatetofIMen/land&Department of streatth and Mental Hygiene 37656 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Danny Mark French Month Dev Year **Physician** French - Daniel М. NOVEMBER 21,2004 /Medical 1:55P. 4c. County of Death 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner 8236 KAVANAUGH ROAD BALTIMORE If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours 12 M 2 □ F 215-74-6044 Maryland Director Aug. 2,1962 Usuel Residence of Decedent Peges 1 and 2 should be filad within 72 hours after death with the Manyand nent of Haalth and Mantal Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☒ No Directo Dundalk Maryland Baltimore 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code ŏ 21222 United States items 23a Completed by Funeral 8236 Kavanagh Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes. Give 1 ☐ Never Married 2 ☐ Married ŏ Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ♣ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Piping & Corrosion 12 Years Utility Man 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be it of Haalth and Mantal Louise French Fred French 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wife 8236 Kavanagh Road Dundalk, Maryland Mrs. Florence G. French 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition THBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Sacred Ht. of Jesus Cem. 11/24/2004 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) a Dilated cardiomyopathy Examiner Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law raquires that the death certificate be executed for use es the bunal-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, that initieted events resulting in death) Last Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? page 2 should be detached 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings 24a. Was an autopsy performed? available prior to completion of cause of death? Yes 2 No 2 No ours efter death.

eral Director: After this certifica
filled in by the funeral director, 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6X Other (Specify) SCENE 1 X Yes 2 □ No 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature of certifier O.C.M.E. NOVEMBER 22,2004 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Dey, Year) State

Registrar

NOV 3 0 2004

				1 - State	State of Ma	ryland /	Department of F Certificate of			201	14	37657
		•		1. Decedent's Name (First, Middle, La	st)		- Cortimodio or	Douth	2. Date of De			3. Time of Death
		Physici		John Joseph Fi	C0070				Month November	Day er 23. 2	Year 2004	10:11 Am
		/Medio Examir		4a. Facility Name (If not institution, giv			4b. City, Town, o	or Location of Death			y of Death	
				Upper Chesapeake M	Medical Cen	iter	Bel Ai	r		Hai	cford	
		Funeral		Social Security Number     6. S	ex 7. Age	(In yrs. last b	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birth	place (State or Foreign intry)
		Director		216-05-6321 Usual Residence of Decedent	X. 23.	93	Yrs.		Dec. 26	5, 1910	_Mar	yland
		land ow		10a. State 10b. County		10c. City, To	wn or Location					10d. Inside City Limits
		Mary Fed sh	to	Maryland Harford	a l	Fore	st Hill					1 ☐ Yes 2 ☐ No
		r 288	irec	Maryland Harrord  10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
		death with the Maryland	a D	2180 Historic Dr:	ive		21050	)		USA		
		ems.	<b>Funeral Director</b>	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent of I tf Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	)- 14. Ra Bla	ce - Ameri	can Indian, etc.
	36	s afte	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯N If Yes, Give	0	1 ☐ Yes 2 ☑ No	Specify:		Specia	fv:	
1	215-0036	hours tural	q pe	15. Decedent's E	Year or Dates:	16	a. Decedent's Usual Occup	nation		16b. Kind of E		ite
1011	15	in 72 n ns Aedic	Completed	(Specify only highest gra	de completed)		(Give kind of work done life. DO NOT use retire	during most of work d)	king	TOD. KING OF E	103111633/111	idustry
	212	d with giene. rr tha	mo	Elementary/Secondary (0-12)	Cottege (1-4or 5-		frigeration	Mechanic		Consti	ructi	on
		e filed at Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last,	)			18. Mother's Nam	e (First, Middle,	. Maiden Sumai	ne)	
	/lai	Menta Menta wrked	To E	John Thomas Fi	ceeze			Agnes I	Barbara	Kaufma	ın	
10	Maryland	2 sho and ls ma		19a. Informant's Name/Relationship (			b. Mailing Address (Street					o Code)
11/23/04		permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menta! Hygiene. Important: If item 27 Is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Mardical Examiliact in 181 be notified at ance.		Marquerite T. Ke.	Liy - Daugn		of Disposition (Name of		Date Mal			
8	Baltimore,	iges 1 if of h if ite or ot		1 ☑ Burial 2 ☐ Cremation 3 ☐		cemet	ery, crematory or other pla	ce)		20c. Location		
1	Iţi	it. Pa		<ul> <li>4 □ Donation 5 □ Other (Special</li> <li>21. Signature of Funeral Service Lices</li> </ul>		Lorrai	ne Park Ceme  22. Name and Addre		26/04	Baltimo	re, I	Maryland
	Ba	permi Depa Impo any ir		the 11/1	Tuck		McComas Fu	ineral Hor	ne Na in ma	Jan Mas	1	a 21000
				23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do	1317 Cokes not enter the mode of dying	ng, such as cardiac	or respiratory a	rrest,	.yrano	Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition			geal Co	encen				Onset and Death
		/Medical		resulting in death)	Due to (or as a							3 1101011
		Examiner		Sequentially list conditions.	b							
		pg tis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	e of):				-	
		xecut and I-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence	of):					
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	687	tificate g phy: as the	edlcal		_ u							
	Box	aath certii attending for use a	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		h 3 Ectopic pregnanc	.,		23d. Da	ate of delive	ery
	m.	The law requires that the death certifules been signed by the attending to has been signed by the attending toge 2 should be detached for use a	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at t		5 Other (specify)	y 		Me	onth	Day Year
	P.O.	uires that the de signed by the a id be detached f	hys	9 Unknown								
		res th ignec	þ	Part II. Other significant conditions of	contributing to death bu	t not resulting	in the underlying cause given	en in Part I.				he cause of death?
	ord	w requir been si should	ted							Tes 2 Ping	3   FIOL	Dably 4 Onknown
5	Vital Records,	has b	Completed						24a. Was autop		Were auto prior to co death?	opsy findings available impletion of cause of
5	H E	cate										2 No
12	VII.	ulcian certif	Be	25. Was case referred to medical examiner?	Hospital:		Otto	26. Place of Deat				
_	o	Phys r this ral di	5.	1 Yes 2 No	28a. Date of Injur	y 28b.	Julpatient 3 DOA	4   Nursing Ho		dence 6 ∐Otł how in∤ury occur		(y)
9	On	ding th: : Afte	tlor	1 ENatural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day	Year)	Time of Injury World M 1	rk?  Yes 2 □ No				
eez	Division	Atter	ifice	3 Suicide 6 Could not b	28e. Place of Inju	ry - At home,	farm, street, factory, office		28f. Location (S City or Tox		ber or Rura	al Route Number,
á	Ö	tal or rs afte al Dir ed in	Certification:	(21)	building, etc.							
Fre		To the Hospital or Attending Phyalcian: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 ☐ Medical Exam	niner: On the basis of	examination a	ge, death occurred at the til and/or investigation, in my o	me, date and place, ppinion, death occur	and due to the red at the time,	cause(s) and m date and place,	anner as s	tated. o the cause(s)
		thin 2 the other	Med	one) 29b. Signature and title of certifier	and manner stat		29c. Licens	se number		29d. Date signe	ed (Month,	Day, Year)
4		F 3 F 8			$\equiv$ $m$ .	D .	D	45390	) /	Joven	ber	24,2004
		(i)		30. Name and address of person who	completed cause of de	ath (Item 23a	) (Type, Print)					
/.		10		WAD WIN CWD	) 602 S	outa.	) (Type, Print) AEWOOD A	wad #	200,	BelA	ir, n	1015 an
-	1	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	& Spor					
	j.	Regist	rar	NOV 3 0 2	1004		to prove	CD'				

State of Maryland / Department of Health and Mental Hygie () [] 37658 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year MEDLEY GRIFFIN 8:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARE CHERRYWOOD REISTERSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) 02 - 22 . 1940 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 218.36.9496 Director MO Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Counts item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Directo MD BALTIMORE KEISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11900 TARRAGON ROAD USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ØWidowed 4 □ Divorced BLACK 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done do life. DO NOT use retired) during most of working and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) NURSE HEALTH CARE 12 TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JACKSON CHARLES ROSETIA LONG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2021 W. LEVINGTON ST., BALTO. MO Department of Health BARBARA WASHINGTON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State KING PARK 12.03.04 BANDAUSTOWN. \* 4 □ Donation 5 □ Other (Specify) 21. Signifure of Funeral Service Licente 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATO PIKE, BALTO. MO 23a. Part1. Sotal the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine the attending physicien and hed for use as the burial-transit that initiated events resulting in death) Last certificate be exec Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown à been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 1 Yes 2 NO funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 🗌 Yes /2 DX6 4 Nursing Home 5 Residence 6 Other (Specify) Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1. Natural 5 Pending М 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 3a) Type, Print) Road Randalistown Mb 21133 Charles E. Moor 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 3 0 2004 Registrar

			= State Registrar	Maryland / Depa	artment of H	lealth and M Death	lental Hygier		37659
	Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> Alice A. Gusmar	10			2. Date of Death November	Dayo 20 Xear	3. Time of Death 10:26 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and num.		4b. City, Town, or	Location of Death		4c. County of Death	
	Examin	C1	Anne Arundel Medical Cent		Annai			Anne Ar	undel
ı	Funeral		5. Social Security Number 6. Sex 7	Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birth	nplace (State or Foreign untry)
L.	Director		051-26-0983  Usual Residence of Decedent	/Z 11s.			Oct. 21	1932	NY
	yland how		10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	Ba-f s	Director	Florida Indian River			Beach			1 Yes 2 XNo
	with the	Dire	10e. Street and Number   21 Vista Gardens Trail #	0.7	10f. Zip Code	32962	10g.	Citizen of What Co	untry?
	death ms 23	Funeral	11 Marital Status 12. Was Deced		Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Amer	
٥	or Ital		Armed Ford  1 □ Never Married 2 ☑ Married  H Yes Give	M No	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Rican, etc.)	Black, White	
	within 72 hours after death with the Maryland jiene. rthan "natural", or Itams 23a or 28a-f show the Medical Every act must be modified at	d by	3 Widowed 4 Divorced  If Yes, Give Year or Date				104		hite
315-UU36	oin 72 n "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of worki f)	in <i>g</i>	. Kind of Business/I	naustry
7	ed within giene. er than "	Com	Elementary/Secondary (0-12) College (1-		nistrative	<u>Assista</u>	nt N'	Y Transit	Authority
and	be filed ntal Hygi td othar avant.	Be	17. Father's Name (First, Middle, Last)				(First, Middle, Maid	den Sumame)	·
2	should nd Men marka umatic	은	Hugh P. O'Reilly  19a. Informant's Name/Relationship (Type, Print)	19h Maili	ng Address (Street	Bridget	Brady al Route Number, Cit	tv or Town State 7	in Code)
<u> </u>	nd 2 salth an 27 ls.		Vincent A. Gusmano	1					
e,	ges 1 and 2 should it of Health and Mer if itam 27 is marke or other traumatic		20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □ Removal from S		osition (Name of matory or other place	e) Dec.	#107, Vei	. Location - City or 1	own, State
saltimore,	Pages ment of tant: If it jury or o		' 4 ☐ Donation 5 ☐ Other (Specify)	Ocean Co	. Memoria				New Jersey
n D	permit. Page Department of Important: If any injury or QDCB.		21. Signature, 1 Funeral-Service licem es	25	2. Name and Addres 3111 MOUI		Stallings d, Pasader		Home, P.A. 122
			23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause in ea	bline.	ter the mode of dyin	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)	EN	15K VOL	em g			Onset and Death
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Ŀ		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (o	as a consequence of):					
	acuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last						
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280	ificate g phys as the	edical	d.						
ž	leath certifica attending pt for use as tl	an/M	230. Was decedent pregnant	ome of pregnancy h 2 Fetal death 3	☐Ectopic pregnancy			23d. Date of deli	,
о п	at the dea by the at rtached fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		Other (specify)			Month	Day Year
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rds,	w requires that been signed E should be deta	ed by					1 Yes	2 □ No 3 □ Pro	bably 4 Unknown
Kecord	~ Q 70	Completed					24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
		Con					performed 1 ☐ Yes 2 ☑	death?	
Vital	Physicien: The this certificate ral director, pag	Be c	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Hospital:	ation of SB(O)	Othe	20	(Check only one)	- Flor: /o	
Ö	ding Phys th. After this funeral di	n; To	27. Manner of Death 28a. Date of	Injury 28b. Time o	IL 3L DOA	4   Nursing no	me 5 Residence 28d. Describe how in		ity)
0	Attending ir death. actor: After by the fune	atlo	2 Accident investigation	Day Year) Injury		Yes 2 No			
DIVISION	l or Attence after death Diractor:	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of building	f Injury - At home, farm, st g, etc. <i>(Specify)</i>	reet, factory, office		28f. Location (Street City or Town, St		ral Route Number,
_	spital norral y filled		29a. Certifier 1 Certifying Physician: To the t	est of my knowledge, deat	h occurred at the time	ne, date and place,	and due to the cause	e(s) and manner as	stated.
	To the Hospital or a within 24 hours after To the Funeral Dirac completely filled in b	ledical	(Check only 2 Medical Examiner: On the bar	is of examination and/or in stated.					
	To T	Σ	29b. Signature and title of centifier	00)0	29c. License	number	29d. I	Date signed (Month	Day, Year)
	3		30. Name and address of person who completed cause	ef death (Item 23a) (Type,	Pripit) / /	0 0 1 13	$\Lambda$	11/01/	200/
	1,		In WEIDSI	-10 600	KIdIH	1 HVH	HON	spolis,	MD
	Sta Registr		31. Date filed (Month, Day, Yaar) 32. Re	pistrar's Signature	dia .			,	
			L/_		Bridge Ball				

			For State Registrar	State of N	Marylan		artmen rtificate					giene Reg. No.	004	37660
	9		1. Decedent's Name (First, Middle	, Last)							2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medic		LaRue R. Gar	nber							Novemb	er 21	2004	10:15 <sup>M</sup>
	Examin		4a. Facility Name (If not institution,	give street and number	er)		4b. City,	Town, or	Location	of Death		4c. Co	unty of Death	
		٠	Paradise Ass						svil]			Ba	ltimor	
п	Funeral		5. Social Security Number 219-26-1518	6. Sex 7. A 1 ☐ M 2 🖾 F	Age (In yrs. 83	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Oct. 30	th i <i>y, Year)</i> 1 1021	9. Birthi Cou Mary	place (State or Foreign ntry)
	Director		Usual Residence of Decedent		0,5						OCL. 3	J,1921	rial y	Land
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	e-fel	ctor	Maryland Balt	imore		Cato	nsvil	1e						1 ☐ Yes 2 反 No
	or 28	Dire	10e, Street and Number				10f. Zip	Code				10g. Citizer	of What Cou	ntry?
	ath w	ra	111 Garden R					212					J.S.A.	
	er de	Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marri	12. Was Deceder Armed Force ad 1 ☐ Yes 2 □	s?	l.S. 13.	Was Deced If Yes, spec	lent of Hi offy Cuba	spanic Ori n, Mexicar	gin? (Spo 1, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Ameri Black, White,	
36	irs aft	by F	3 Midowed 4 Divorced	If Yes, Give Year or Dates	-		1□ Yes	ZK MNo	Specify:			Sp	oecify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ane. then "natural; or items 23e or 28e-1 ehow the Madral Exami har rust be notified at	ted	15. Decedent			16a. Dece	dent's Usua	I Occupa	ation	4 - 4 · · · a · · ·		16b. Kind	of Business/In	
215	thin 7 e.	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4c	or 5+)	life.	kind of wor DO NOT us	e retired	) )	I DI WOIK	ing			
	filed wi Hygien other th	Co	9			Se	wing	Inst					iger Co	mpany
Maryland	be fill htal H ed oth	Be	17. Father's Name (First, Middle, I								e (First, Middle		•	
Ž	hould d Mer narke natic	은	Royal Dewey John 19a. Informant's Name/Relationsh			10h Mailir	na Addrose	(Street a		36	Lizabet a <i>l Rout</i> e <i>Numb</i>			a Coda)
Ma	d 2 sl th an t7 ls r treur		Myra L. Schmits	(Daughter	.)		. Mar				erlin,			100.1
	Heal Heal tem 2		20a. Method of Disposition	(Baagii ee	20b. F	Place of Dispo	sition (Nan	ne of	1		Date		tion - City or To	
e E	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		te Cre	cemetery, crei stlawn rdens	Mémo	rial	9) ;	11_2/	4-2004	Marrio	ttewil	1 MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f ehow any injury or other treumatic event, the Madical Examiner of usible notified at 2002.		21. Signature of Funeral Service I		STEEL STATE		2. Name an	d Addres						
m	Departing Department on in in processing the proces		P S S	MODE	~00	869 W	630 E	dmon	dson	Aver	e of Ca nue Cat	onsvi]	le, MD	21228
			23a. Parti. Enter the disease, or shock or heart failure. List	complications that caus	ed the deat line.	Do not ent	ter the mod	e of dying	g, such as	cardiac (	or respiratory a	rrest,		Approximate Interval Between
J.	Physician		Immediate Cause (Final disease or condition	a	V	ascula	~ )	Pme	entiq					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consec	quence of):								
		<u>.</u>	Sequentially list conditions,	b. Due to (or :	as a consec	mence of):								
-	rted nsit	nine	if any, leading to immediate cause. Enter Underlying	500 10 (0.1	uo u 0011000	140.100 01).								
,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or a	as a conseq	uence of):								
760,	death certificate be executed e attending physician and od for use as the burial-transit	cal		d										
89	es that the death certificate igned by the attending phys be detached for use as the		IF FEMALE:										1	
Вох	ath ce ttendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Feta	al death 3	]Ectopic pr					230	. Date of delive Month	ery Day Year
0.	ne dea the at hed fo	by Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		death 5	Other (sp	ecify)					MONT	Day Tour
4	requires that the een signed by th nould be detache	Ph	Part II. Other significant condition	ns contributing to death	but not res	sulting in the u	nderlvina c	ause give	n in Part I		23e. Did t	obacco use	contribute to t	he cause of death?
Records,	signe d be			· ·		•	, ,	3			10	Yes 2 1	lo 3□Prot	pably 4 Dinknown
CO	~ Q to	Completed							_		24a. Was	an 2	4b. Were auto	opsy findings available
Re	9 2 9	dwc										psy prmed?	prior to co death? 1 \( \text{Yes}	mpletion of cause of 2 \( \subseteq \text{No} \)
Vital	icien: Th certificate rector, pag	Be C	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes	2 No	1 195	2L NO
f V	Physicien: r this certific ral director,	To E	examiner?	Hospital: 1 Inpa	atient 2	ER/Outpatier	nt 3 DC	A Othe	ar: 4 □ Nu	ırsing Ho	me 5 Resi	dence 6	Other (Specif	W 15515ted
n of	ng Pt fter th ineral		27. Manner Ceath  1 tural 5 Pendin	28a. Date of li (Month, l	njury Da <i>y Ye</i> a <i>r</i> )	28b. Time o Injury	f 2	8c. Injury Work			28d. Describe	how injury o	ccurred	111119
Sio	Attending r death. ector; After by the fune	catl	2 Accident investig	ation			М		Yes 2□					,
Division	or At offer d Direct in by	Certification:	4 Homicide determ	and 286. Place of	etc. (Special	ome, fam, str fy)	reet, factory	, office			City or To		lumber or Rura	al Route Number,
	pitel	S	29a. Certifier 1 Certifyin	g Physician: To the be	st of my kno	owledge deat	h occurred	at the tim	ne date an	nd place	and due to the	cause(s) an	d manner as s	tated
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical one)	Examiner: On the basis and manner	s of examina	ation and/or in	vestigation.	in my or	pinion, dea	th occurr	red at the time,	date and pla	ace, and due to	o the cause(s)
	within To the compl	Me	29b. Signature and title of certifier	4.0				-	number			,	igned (Month,	Day, Year)
			I taymore	Mille Mrs				D4°	768	3		11/23	104	
/	10		30. Name and address of person		-									
1	1,		Thyrond Miller	25 Main Som	er Su	ute 20	> Ren	sterst	PWA	N2	>			
	Sta Registi		31. Sete filed (Month, Day, Year)	0 2004 32. Hegi	Parar's Signa	ature	1 1	Down	Cs/					
	riogiot	40	INO A 9	O LOO!			- *							

mend Items 7,10e,20b per Inf. 6839 01/04/2005dhb and Mental Hygiene Manual Item 10e per In 6838 12-10-04 Las		•
Amond Thom 100 points of wathrand A Debartherit of Health and Merital Hygieries ()	- •	
	$\cap$ $I$	ļ
Amend Item for per in 6030 12-10-04, Las	1 6	,

			Amend ]	Item 10e	per th G	381922	Ueba Cert	riment of the tast	nealth and l Death	мептат Ну	giene 0 (	) 4	37661
	6		1. Decedent's Neme			<u></u>				2. Dete of De		Year	3. Time of Death
	Physici /Medi		FLOREN	CE A. G	OYNES					NOV	18 20	204	4:00 Am
1	Examir				rive street end number				4b. City, Town, or I	Location of Deat			
					RSING CENTE			If Under 1 Year	ARNOLD  If Under 24 Hrs.	0.0-1-40:	ANNE A		
	Funeral Director		5. Social Security Nu 220–30–	0385		ge (In yrs. lest b	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 6-12-	1907	9. Birthp Coun MARY	lace (State or Foreign htry) LAND
	Maryland f show	ō	Usuel Residence of 10a. Stete MD •	10b. County ANNE AI	RUNDEL	10c. City, To		ation				1	0d. Inside City Limits
	with the last or 28a-	Direct	10e. Street end Num	1230 FC STAT	Jones Sta	tion Rd	l.	10f. Zip Code 21012	)		10g. Citizen of V	Vhat Coun	try?
020	filed within 72 hours after death with the Marylend Hygiene. Ither than "natural", or frems 23a or 28e-f show with the Medical Evantiner must be notified at	Completed by Funeral Director	11. Merital Status 1 □ Never Marrie 3 □ XWidowed	ed 2 Married	12. Was Decedent	? No			Hispenic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. Rac Blac	e - Americ k, White, BLA	etc.
215-0	hin 72 ho s. nn "natur Medical	pleted			Education grade completed) College (1-4or		Give k	ent's Usual Occup ind of work done O NOT use retire	petion during most of wor d)	kin <b>g</b>	16b. Kind of Bu	usiness/Inc	lustry
7	od wit	Ö	-3-	104.7 (5 12)	-0-			COOK			DOMES	TIC	
Ind	be file d oth	Be	17. Father's Neme (		st)						, Ma <i>iden Sum</i> am	Θ)	
yla	should be and Mental marked or umatic eve	ို	WILLIAM							E BARNE			
Mai	nd 2 sh aith and 27 is m ir traum		19a. Informant's Na AGNES CI				_		and Number or Ru FATION RD				Code)
Baltimore, Maryland 21215-0020	permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylen Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28e-f show any Injury or other traumatic event, the Medical Examiner must be nortified at once.		4 □ Donation  21. Signature of Fur	Cremation 3 5 Other (Special Service Lice		Ashur	22.		Church TEX 1 SCIENT WI ST. ANNA	LLIAM R	EESE 9 S	IARGAI	RETS, MD.
		П	23a, Part1, Enter th	disease, or	mplications that cause ly one cause on each l	d the deeth. Do	o not enter	r the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate tnterval Between
	Physician /Medical Examiner		Immediate Cause (F disease or condition resulting in death)	Final	· META		16	CARCI	Noma	-LINKA	OLUN		Onset and Death
	*	Jer				Due to (or as	a consequ	ence of):		PRIM	ARY		
60,	ficete be executed g physician end es the bunel-transit	edicai Examiner	Sequentially list con if eny, leading to imi cause. Enter Under Ceuse (Diseese or i that initiated events	nditions, mediate rlying injury	c	Due to (or as a	a consequ	ence of):					
ox 68760,			resulting in death) L	ast	■ d	Due to (or as e	e conseque	ence of):					
Box	death a atter d for i	Icla	Part II Other elonific	cant conditions	contributing to death t	out not resulting	in the unc	derlying cause on	ven in Part I	23b. Did	tobecco use cor	tribute to	the cause of death?
P. 0.	d by the	Phys			, , , , , , , , , , , , , , , , , , ,	•	,	,			Yas 2 No		oably 4 🗆 Unknown
Division of Vital Records,	The law requires that the death certif ste has been signed by the attending page 2 should be deteched for use a	Completed by Physician/M				-					en autopsy ormed?	ava	ere autopsy findings allable prior to npletion of cause death?
æ	The Ig	E O								10	Yes at No	1 🗆	Yes 2□ No
ita	rtifice ctor, p	Bec	25. Was case referre	ed to medical					26. Place of Dea				
<u>&gt;</u>	nystci nis ce I direc	P	1 ☐ Yes 2 ☑	No	Hospital: 1 ☐ Inpati	ent 2 ER/C	Outpatient	3LI DOA		ome 5 ☐ Resi	dence 6 □Oth	er (Specify	')
ouo	ding Pt th. After the funera	tion:	27. Manner of Death 1    Natural 2   Accident	5 Pending investigat	28a. Date of Inji (Month, Date)		. Time of Injury	28c. Injut Wor M 1 □	ry et rk? Yes 2 □ No	28d. Describe	how injury occurr	ed	
Divisi	i or Atten efter dea Director	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine		jury - At home, lc. (Specify)	farm, stree	et, factory, office		28f. Location ( City or To	Street and Numb vn, State)	er or Rura	l Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours effer death.  To the Funers! Director: After this certificete hes completely filled in by the funeral director, page 2	Medical C			Physician: To the best aminer: On the basis of end manner st	f examination a							
	Within To th Comp	Ž	29b. Signature and t		1			29c. Licens			29d. Date signed		
	h)		PVVG	nig	i, mD				7531		NOV 18	3, 20	204
	8		<ol><li>Neme end addre</li></ol>	ess of person wh	o completed cause of (				litersu	ue re	02116	8	
1	Sta Registr	te ar	31. Dete filed (Month	h, Day, Year)	32. Regist	rar's Signature	2						
1			NO	17 4 U - 28	3736	1200	A CA	11 1					

ORIGINAL

DHMH 16 Rav 6/95

				State of Ma						•	ene .			
			1 - For State Registrar				rtificate of				No. UU	4	37	662
ı	Physici	ian	1. Decedent's Name (First, Middle, Las	()		GILLA			, M	ate of Death onth	Day	Year		of Death
	/Medi Examir		AMANDA KEZ 4a. Facility Name (If not institution, give	street and number)	, 1	GILLA	4b. City, Town, o	or Location of		ember	4c. County	of Death		103
1	Exami		The Johns Ho	OPKINS 1	4asp	ital	Balti	more		4		A/N		
	Funeral Director		5. Social Security Number 6. Se 220 – 19 – 1532	711 0000	e (In yrs. 12 18	ast birthday) Yrs.	Months Days	If Under 24 Hours	4 Hrs. 8. Da	ate of Birth Nonth, Day, Y	ear) 1086	9. Birth	place (Staintry)	te or Foreign
	P		Usual Residence of Decedent	XX					mai	CII 23,	, 1300			
	Aarytai f show	ō	10a. State 10b. County			Town or Lo	cation							es 2No
	r 28a-	by Funeral Director	Maryland Harford 10e. Street and Number		ADII	igdon	10f. Zip Code			10g	. Citizen of W	/hat Cou		ΛΛ
	ath wit	raiD	446 Abbey Circle				2100				USA			
	ter de	-une	11. Marital Status  1XXvever Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2		S. 13. Y	Was Decedent of H f Yes, specify Cub	lispanic Origi an, Mexican, I	n? (Specify Y Puerto Rican,	es or No- , etc.)		- Ameri k, White,	can Indian etc.	•
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinations to rotified at	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I□Yes XX No	Specify:			Specify	WI	nite	
15-0	n 72 h "natu edicul	Completed	15. Decedent's Edi (Specify only highest grad	de completed)		(Give	lent's Usual Occup kind of work done OO NOT use retire	during most of	of working	16	b. Kind of Bu	siness/In	dustry	
212	d withi	Juo	Elementary/Secondary (0-12)	College (1-4or 5	+)		Student	-/			Edu	ıcat:	ion	
nd	ould be filed with Mental Hygiene. arked other than latic event, Illum	Be	17. Father's Name (First, Middle, Last)	land					s Name <i>(First</i> Sandra		den Sumam	e)		
Maryland	should nd Men	2	Bruce Courtney Gil  19a. Informant's Name/Relationship (T)			19h Mailir	g Address (Street				ity or Town	State Zir	Code)	
	1 and 2 sho Health and Iem 27 Is my		Bruce C Gilland	Fatl	ner		Abbey Cir							
ore,	ages 1 and of He in tof He or other		20a. Method of Disposition  1 Burial 2YYCremation 3 D	Removal from State	20b. Pla	ace of Dispo	sition (Name of natory or other plac	ce)	Date	200	. Location -	City or To	own, State	
Baltimore,	t. Pertrant		1 ☐ Burial 2XXCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,		Gre		nt Cemete				Baltimo			
Ba	Depar Impor any ir		James Year	W Nena	Ken	) "	. Name and Addre		York Roa	ell-Wied ad Balti				
г		7	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused no cause on each lin	the death.	. Do not ente	er the mode of dyir						Approxim Interval B	nate Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)				BRAIN	INJUR	7.				Onset an	
	Examiner			Due to (or as a	1120	ence of):							2 de	1111
	p #	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Dine to (or as a		ance off:								J.
	xecute and al-trans	Examiner	that initiated events resulting in death) Last	c. HEMOPTO		ence of):							3 da	rys
760,	aath certificate be executed attending physician and for use as the buriat-transit	calE		d	·									
89	artificat ing phy e as th		IF FEMALE:										~ ~	
Вох	attend for us	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t	2 Fetal	déath 3□	Ectopic pregnancy Other (specify)	,			23d. Date Mon		ory Day	Year
0	at the de by the a tached	hysic	1	9□ Unknown		uu	Cirio (specify)							
S, P	as this	by	Part II. Other significant conditions co.			-			23	Be. Did tobaco				
ord	w require been si	eted		NT END					_	1 🗆 Yes				Unknown
Vital Records,	The law cate has page 2 s	Completed	FOR AL SEGMENTAL	6 LOMERUI	AR	SCLERO	5 (L			a. Was an autopsy performed	?   pr	ior to cor eath?	mpletion of	s available cause of
ita		Be C	25. Was case referred to medical examiner?			-		26. Place of	f Death (Chec	Yes 2 🗆	No 11	_] Yes	20 No	
of V	shys this al di	P	1 Yes 2 No	lospital: 1 Inpatier		R/Outpatient	3 DOA Oth	er: 4 🗌 Nursi	ing Home 5				1)	
on	ding h. After funer	tlon	Natural 5 Pending 2 Accident investigation	(Month, Day	Year) '	28b. Time of Injury	28c. Injur Wor M 1	yau k? Yes 2.∏No		escribe how in	njury occurre	a		
Division	or Attendiater death. Director: A	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc.	ry - At hon (Specify)	ne, farm, stre	et, factory, office			cation (Street by or Town, St		r or Rura	l Route Nu	ımber,
	To the Hospital or At within 24 hours after C To the Funeral Direc completely filled in by	Cer	29a. Certifier 1 Certifying Phy											
	te Hospital 24 hours a te Funeral detely filled	edical	(Check only 2 Medical Exami	sician: To the best of ner: On the basis of and manner stat	examinatio	on and/or inv	estigation, in my o	pinion, death	occurred at th	e to the cause ne time, date	and place, ar	ner as si id due to	ated. the cause	e(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	1			29c. License				Date signed	(Month,	Day, Year)	
	di		1991	V >			RES	- 000		N	NEMBE	R Z	28, 2	00 4
	10		30. Name and address of person who co	ompleted cause of de	ath (Item : WOL		Print)	LTIMOR.	= MI)				,	
	Sta		31. Date filed (Month, Day, Year) NOV 3 0 20	32 Ponitytra			J/ 12	-11/10/00						
	Registr	ar	HO 6 9 () 2()	U4 Ben	مهسي	6		· !						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygießen n. I.

			For State Registrar	State of Ma	aryland / De	partment of Fertificate of	lealth and <i>Death</i>	d Mental Hy	gie De 0	37663
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month		3. Time of Death
	/Medic		George Leo Han					NOVEME		
	Examin	er	4a. Facility Name (If not institution, give s Saint Joseph	Medical		4b. City, Town, o		vson		altimore
	Funeral Director		5. Social Security Number 6. Sex 213-28-0821	M 2□F 7. Age	e (In yrs. last birthda 74 Yrs.	Months Days		in. 8. Date of Bir /Month, Da July 2	15, 1930 N	D. Birthplace (State or Foreign Country) Aaruland
	D .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Lacation				10d Inside City Limite
	laryla shov	<u>_</u>			100. City, Town of					10d. Inside City Limits 1 ☐ Yes 2 1 No
	the N	Director	Maryland   Baltimore			10f. Zip Code	imore	<u>-</u>	10g. Citizen of Wh	
	3a or		4700 Beaconsfield	Drive			212	36	u.s.,	
	ter death	Funeral		2. Was Decedent   Armed Forces?	Ever in U.S. 1	3. Was Decedent of H	lispanic Origin?	(Specify Yes or No		American Indian, White, etc.
36	be filed within 72 hours after death with the Maryland all tygiene. did bylygiene dether than "naturel", or feme 23a or 28e-f show other than "naturel", or feme 23a or 28e-f show event. I've Medical Exatic national be notified at	by Fu	1 ☐ Never Married 2(X) Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 1 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☒ No	Specify:	one moun, sto.,	Specify:	White
21215-0036	2 hou	ted	15. Decedent's Educ	ation	16a. De	pedent's Usual Occup	ation		16b. Kind of Busin	ness/Industry
215	thin 7 e.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	ife	ve kind of work done  . DO NOT use retired	d)	working		
21	ed wi	S	8th Grade		Cri	ine Operat			Steel	Company
Maryland	ed is b	o Be	17. Father's Name (First, Middle, Last)  John P. Hanlon					e E. Do	o, Maiden Sumame) Olinger	
ary.	ges 1 and 2 should t of Health and Men If item 27 le marke or other treumatic	၉	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Ma	iling Address (Street				ate, Zip Code)
	and 2 salth a n 27 le		Mrs. Linda Hanlon	(wife	) 47	00 Beacons	field D	rive, Bal	ltimore, 1	MD 21236
ore	of He of He fitem		20a. Method of Disposition 1	emoval from State	20b. Place of Dis cemetery, c	position (Name of rematory or other place	сө)	Date	20c. Location - Ci	ty or Town, State
ij	Pag ment tent: I		'4 ☐Donation 5 ☐ Other (Specify)		Oak Law	n Cemetery	1 11/	27/2004	Baltimor	e, Maryland
Baltimore,	permit. Pages 1 and 2. Department of Health ar Importent: If item 27 leany injury or other treugnce.		21. Signature of Funeral Service License	les s		22. Name and Addre	ir Rd.,	chimunek Baltimo,	Funeral H	Homes 236
	- "		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused e cause on each lin	the death. Do not e					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	RUPTU	RE ABDOM	INAL AOR	TIC AN	IEURYSM		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
		er	Sequentially list conditions, if any, leading to increase acuse. Enter Underlying Cause, Obsease or injury	Due to (or as	a consequence of):					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
oʻ	e exec	Exa	resulting in death) Last		a consequence of):					
8760,	icate be executed physicien and s the burial-transit	dical								
9 xo	eath certific attending p	O O	IF FEMALE:	3c. If yes, outcome	of pregnancy				224 5-4-	6 4-15
B	atten affor us	Physician/M	in the past 12 months?		2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	у		23d. Date of Month	
0	that the dead by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown						
S, P	se un eq	by	Part II. Other significant conditions con	tributing to death b	ut not resulting in the	underlying cause giv	en in Part I.		$\checkmark$	ute to the cause of death?
Records,	w require	Completed				· · · · · · · · · · · · · · · · · · ·		- 10	7	☐ Probably 4 ☐Unknown
Sec	e law has b	mple						24a. Was	psy pric	re autopsy findings available or to completion of cause of ath?
alF	siclen: The law certificate has t irector, page 2 s							1 ☐ Yes	2 No 1	Yes 20 No
Vital	Physiclen: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	ent 2 ER/Outpat	ient 3 DOA Oth	200	Death (Check only	one) idence 6 □Other	(Specify)
of		n; To	27. Manner of Death	28a. Date of Inju	ry 28b. Time	of 28c. Injur	v at		how injury occurred	
ion	ttending F death. ctor: After y the funer	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Mortin, Da	y Year) Injur		Yes 2 □ No			
Division	for Attence after death Director:	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm, c. <i>(Specify)</i>	street, factory, office			(Street and Number wn, State)	or Rural Route Number,
]	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After The Funerel Director or To the Funerel		(Check only 2 Medical Examin	ner: On the basis of	f examination and/or	eath occurred at the till investigation, in my o	me, date and pla opinion, death o	ace, and due to the	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
	thin 2 the the l	Medical	one) 29b. Signature and title of certifier	and manner sta	ated.	29c. Licens	se number		29d. Date signed (	Month, Day, Year)
	+ ≥ F B		1 MOF	the same		n o	3427		111-	24/2
1	DH.	7	30. Name and address of person who co	mpleted cause of d	leath (Item 23a) (Typ				"//	TUY
	01		MOUHAMAD ANNOU	5 M.D.	7601 OSM	ER MRIUE	. Zowsc	N MARYL	OND SIST	214
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	sporte		1100		
	ricgist	4	MOARA	17						

_			For State Registrar		State of Ma		epartmen Certificat			and M		giene Rog. No. 2 (	004	37664
	Physicia /Medic		1. Decedent's Name (#	First, Middle, Last) Pe HA	TTEN						2. Date of De Month	Day	Year 2004	3. Time of Death 7:11 PM
	Examin	er		AGNES	HEALTH		P	AL	Location of	ORE	7		ty of Death	
	Funeral Director		5. Social Security Num  223-34-  Usual Residence of De	D825 10	7. Age	(In yrs. last birth	rs. If Under	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year) . 029	9. Birthpl Count	ace (State or Foreign
	Maryland -I show	tor		Ob. County		10c. City, Town	or Location	100	10,				10	0d. Inside City Limits 1 XYes 2 □ No
	with the	Funeral Director	10e. Street and Number		RST AL		10f. Zip	Code	216	3		10g. Citizen of	What Count	*
ď	pornit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menall Hygiene. Important: I flam 27 Is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant. I've Medical Examinar must be notified at once.	/ Funera	11. Marital Status	2 Married	2. Was Decedent E Armed Forces? 1  Yes 2 N If Yes, Give	ver in U.S.	13. Was Deced		spanic Origin, Mexican	gin? (Spe n, Puerto f	cify Yes or No Rican, etc.)	14. Ra Bl	ace - America	atc.
21215_0026	"natural",	leted by	3 XWidowed 4 [ 15 (Specify	Divorced  5. Decedent's Educionly highest grade	Year or Dates: ation	1 1	Decedent's Usua Give kind of wo life. DO NOT u	al Occupa	ition	t of workir	ng	16b. Kind of	, DL	ACK
	a y allo within 2 should be filed within and Mental Hygiene. Is marked othar than aumatic avant. I'm Mental warmatic avant.	e Completed	Elementary/Seconda	de	College (1-4or 5-	·)   C	are	Prov	ides	er's Name	(First, Middle	STAT		MD
pachach	should be ind Mental in marked o	To Be	JUSSIL R	ichards e/Relationship (Typ		19b.	Mailing Address					Richar Br. City or Town		
	Te, INC 1 and 2 a 7 Health ar itam 27 is other trau		CASSIE L 20a. Method of Dispos	- Factor	ey/Daugl	nter 53	32 Run Disposition (Nar crematory or o	ne of	n Ro	ad A			. MD a	21229
Cachimore	permit. Pages 1 and Department of Health Important: If item 27 any injury or other trong.		↑ A Donation 5				more N	ATL						
à	Departi Departi Importa any inji		23a. Park. Enter the	disease, r complic	cations that caused e cause on each line	the death. Do no						BALLO,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Fir disease or condition resulting in death)		m	YOCAR.		11	FA	mc?	70~			Onset and Death
	Examiner	ner	Sequentially list condition and leading to immediate.	tions, b.		consequence of	):							<del></del>
260 €	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	i Examiner	Cause (Disease or injuthat initiated events resulting in death) Las	urý	Due to (or as a	consequence of	):							
ď	eath certificate that attending physical for use as the the the the the the the the the the	/Medicai	IF FEMALE:	d.	Bc. If yes, outcome of	of pregnancy								
G G	the death of the attenched for u	Physician/Med	23b. Was decedent pr in the past 12 mg 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	potis?	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 Fetal death	3 □Ectopic pr 5 □ Other (sp			<u> </u>			ate of deliver onth	y Day Year
PRH P	quires that the de	by	Part II. Other significa	ent conditions conf	tributing to death bu	t not resulting in	the underlying c	ause give	n in Part I.					cause of death?
310. /	The law requi	Completed											prior to com death?	sy findings available ipletion of cause of
1EN	Physician: The this certificate had director, page	To Be C	25. Was case referred examiner? 1 \( \text{Yes}  2 \text{No} \)	- 11	ospital: 1   Inpatier	nt 2 ER/Out	patient 3 DC	Othe			(Check only o			
7FH Joyicion of	After fune		2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day	Year) 28b. Ti	me of 2 ury M	8c. Injury Work	at ? ′es 2 □ l	2		how injury occu		
, ivid	To the Hospital or Attant within 24 hours after death to the Funaral Director: completely filled in by the	Certification:	4  Homicide	6 Could not be determined	28e. Place of Inju building, etc.	. (Specify)				į.	City or To	wn, State)		Route Number,
	To the Hospital within 24 hours a To tha Funaral I completely filled	Medical	(Check only 21 one)	_ Medical Examin	ician: To the best o er: On the basis of and manner stat	examination and	or investigation	at the tim , in my op c. License	inion, deat	d place, a th occurre	d at the time,	date and place	and due to	the cause(s)
•	To with	-	29b. Signature and titl	le	(ln)		Ĺ	00.	518				MBER	23, 2004
1	4		30. Name and address  HM2 v  31. Date filed (Month,	cs 00	RTIS	ath (Item 23a) (T	ype, Print)	MO	SP17	200	31	HIM	ore	, ns
	Stat Registra			V 3 0 2004		Jan Jan	Spi	res	/					

			1 - For State	State of Maryland	/ Depa	artment of h	Health and	Mental Hygi	iene 20	04	37665
			Registrar  1. Decedent's Name (First, Middle, Last)			inoute or	Death	2. Date of Deat	·g. 140.		3. Time of Death
	Physicia	an	Vernon N.	Haves				November	Day	Year 2004	12:10 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Deat			ty of Death	
	LAGITIM		Genisis Elder Care	е		Severr	na Park		An	ne Ar	undel
	Funeral		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs Hours Min				place (State or Foreign intry)
	Director		214-26-4101	M 2□F 8!	O Yrs.			Nov. 15			KY
and	*		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
Maryl	faho	ō	Maryland Anne Ar	undo1		_	asadena				1 Yes 2 No
the	r 28a-	rect	10e. Street and Number	under		10f. Zip Code	asauena	10	Og. Citizen of	f What Cou	intry?
h with	38 0	Funeral Director	7668 Pine Haven D	rive		2	21122		1	USA	
deat	E E	ner		12. Was Decedent Ever in U.S. Armed Forces?	13.			Specify Yes or No- to Rican, etc.)	14. Ra	ace - Ameri ack, White	
after	or it	J. F.	1 Never Married 2 Married	1 XYes 2 ☐ No If Yes, Give		1 ☐ Yes 2 🖫 No		, ,		ity: Wh	
be filed within 72 hours after death with the Maryland	ital Hyglane. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 □XWidowed 4 □ Divorced  15. Decedent's Edu	Year or Dates:	160 Dagg	dent's Usual Occur	nation		16b. Kind of		
n 72	an La	iete	(Specify only highest grade	e completed)	(Give	kind of work done DO NOT use retire	during most of wo d)	orking	100. Kind of	DUSITI <del>O</del> SS/II	loustry
with	thar thar	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Mechani			Heavy	Faui	nment.
	othe vent,	BeC	17. Father's Name (First, Middle, Last)					me (First, Middle, N			
d blu	and Mental Hyglene, is marked other the eumatic event, the h	5	James W.	Hayes			Laura	J.	Do	tson	
2 should	and l	Ė	19a. Informant's Name/Relationship (Ty					ural Route Number,			p Code)
and	f Health and Men item 27 is marke other treumatic			daughter)		3 Pine Ha	ven Dr.,	Pasadena			- Challe
988	it of H		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □ F	lemoval from State cen	netery, crer	natory or other pla	Dec.	. 02	20c. Location	•	
r. Pa	artmen ortent: injury e.		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Europeal Service Signature</li> </ul>			Cemeter  Name and Addre	ry 20				Maryland
perm perm	Department of Health a Importent: If item 27 is any injury or other tre and injury or other tre		21. Signature of parteral Service racens	, V				d, Pasade	is Fune	eral 1	Home, P.A.
- 1			23a. Part1. Enter the disease, or conol shock, or heart fellure. List only by	ications that caused the death.						, 2112	Approximate
Die	velalan		Immediate Cause (Final		_						Interval Between Onset and Death
	ysician Medical		disease or condition resulting in death)	Due to (or as a consequent		nbolism					
Ex	aminer		Conventially list and drives	Atnal	Pibril	ation					
	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque							
acute	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (d'as a conseque	son-						
,	sician and burial-transit	cai E	resulting in deality and	Benign		atic hy	how protopy	A			
VISION OF VILLE DECOLOS, T.C. BOX 00100, Attending Physicien: The law requires that the death certificate be executed	attending physic d for use as the b	edica		1200190.			r	1			
certif	nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnand					23d. D	ate of deliv	rery
death	d for	iciai	in the past 12 months?	1 Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea		]Ectopic pregnanc ] Other <i>(specify)</i> _	у		N	Month	Day Year
the c	by the	Physician/M	9 Unknown	9□ Unknown							
s tha	certificate has been signed by the attendin rector, page 2 should be detached for use	by P	Part II. Other significant conditions con	4.	_	11					the cause of death?
w requires	ould I		Chronic obst	inctive pulm	vonav	y drised	We	1 □ Ye	s 2 LINO	3 [] Pro	babiy 4 Munknown
a v	as be	Completed	<del> </del>					24a. Was ar autops	y	prior to co	opsy findings available ompletion of cause of
The	page	Con						perform 1 Tes 2	No No	death?	2 🗆 No
clen:	sertific	Be	25. Was case referred to medical examiner?	lospital:	-	OH	CHARLE IN S.	ath (Check only one			
Phys	this ral dir	. To	1 Yes 2 No	1   Inpatient 2   E	R/Outpatier 8b. Time o	IL 3 DOX	4 Lativui sirig	Home 5 Reside			fy)
ding C	h, After this funeral di	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	rk? Yes 2 □ No		,.,,		
Attending	ctor:	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom	ne, farm, str	eet, factory, office		28f. Location (Str		nber or Rui	al Route Number,
5 5	s after	Certification;	4 Homicide	building, etc. (Specify)				City or Town	, State)		
lospit	within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical (	(Check only 2 Medical Exami	sician: To the best of my know ner: On the basis of examination	ledge, deat	n occurred at the ti	me, date and plac opinion, death occ	e, and due to the ca urred at the time, da	use(s) and nate and place	nanner as :	stated. to the cause(s)
the	thin 24 the F mplete	Medi	one)  29b. Signature and title of certifier	and manner stated.		29c. Licen			d. Date sign		
70	¥ 7 8		by A State of State o	Physici	an				_		
	10		30. Name and address of person who or	ompleted cause of death (Item 2	23a) (Tyne	Print)	A	11/	Λ		7-1
	V		30. Name and address of person who con Naemeka Again	ajelu 8094	Edm	n Kayno	~ (3/v)	suite A	Pasade	ina, l	30, 2004 ND 21122
	Sta	ate rar	31. Date filed (Month NO 193)	32. Regist ar's Signatu	re	9 6	100				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Year Physician NOVEMBER 12:10 AM 18 2004 Donald J. Harrison /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctors Community Hospital Lanham Prince George's 8. Date of Birth (Month, Day, Y Nov. 14, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Year) 1917 **Funeral** 1**X** M 2□ F 194-09-1458 87 Pennsylvania Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the McCleal Examiner next be natified at 1 X Yes 2 No Director Maryland | Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23e or 20715 Be Completed by Funeral 12818 Belhurst Lane U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ö 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 XWidowed 4 □ Divorced "naturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) if Health and Mental should be Javie Harrison Mildred C. Rothrock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Maryann Steinbauer (Daughter) 12818 Belhurst La., Bowie, MD 20715 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Department of Importent: If it ö 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Calvary Cemetery 11/20/04 Altoona, PA 4 □ Donation 5 □ Other (Specify) eny injury 22. Name and Address of Facility
Stevens Mortuary permit. 21. Signature of Funeral Service Licensee 1421 Eighth Ave., Altoona, PA 16602 ennus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Approximate Interval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Duesto (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably Unknown 2 🗆 No Neumon 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the funeral director, page 2 autopsy performed? 2 🗆 No 1 BRILL 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification; To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 2 🗆 No 1 Tyes investigation Director 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 T Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 | Homicide within 24 hours a To the Funeral I the Hospitel 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) none Name and address of person who completed cause ordean (Item 23a) (Type, Print) State Registrar

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** orchens Ceonya 2004 /Medical 4a. Facility Name (fi not institution, give street and number) 4c. County of Death Examiner Helical Baltimore Center 12/04 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)

 D 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days 33 1 🗆 M Yrs. unknown Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show treumatic event, the Madical Examiner orust be notified at 1 Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? USA LEXINGION Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after Never Married 2 Married 3 Widowed 4 Divorced Yes 2 No Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 A No Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 NONE 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if tiem 27 is marked oth eny injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) Be BURGESS HOUCHERS TonyA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FATHER 31 WEST +611 St TEON +P 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 11/29/2004 Woodlawn, Maryland A □ Donation 5 □ Other (Specify) 21. Signature of Funaral Service Licenses 22. Name and Address of Facility
Sterling Ashton Schwab Funeral Home, Inc.
736 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TRI Somy /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending IF FEMALE for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 Probably 4 Anknown Completed page 2 should 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes No certificate has Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify, Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA After this funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the 30. Name and address of person of completed cause of death (Item 23a) (Type, Print) odu 30 1 FT / C , Baltmor 31. Date filed (Month, Day, Vear) 0 State Registrar

			State of Maryland / Department of Health and Mental Hygien 2004 37668
			1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time
	Physici /Medic		Virginia Marie Holland Nov. 24, 2004 1:25P M
П	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
		٠	Civista Medical Center La Plata Charles
	Funeral Director		5. Social Security Number 6. Sex 1 $\square$ M 2 $\square$ F 7. Age (In yrs. last birthday) 79 Yrs. The last birthday) 1 $\square$ Months Days Hours Min. (Month, Day, Year) 3 $\square$ MD 9. Birthplace (State or Foreign Country) MD
	9		Usual Residence of Decedent
	arylar show	7	10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits           MD         Baltimore         Rosedale         1 □ Yes 2 ☒ No
	28a-f	ecto	MD Baltimore Rosedale 1 □ Yes 2 ☒ No  10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	3a or	Funeral Director	7910 Montrose Ave 21237 USA
	death	ner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Hybrid Rican, etc.)
9	s after	by Fu	1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do thyse then "neturel", or Items 23a or 28a-f show of other then "neturel", or Items 23a or 28a-f show event, I're Medical Examirar must be notified at	ed b	15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry
212	thin 7: e. en "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)
2	filed wi Hygien ther th		12 0 Homemaker Own Home
anc	be d d	b Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  Henrietta Unknown
Maryland	de E	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	and 2 ealth a m 27 Is		Mark Holland/Son 7720 Carrico Mill Rd. Charlotte Hall MD 20622
ore E	iges 1 and to f Healt if item 2 or other		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  20c. Location - City or Town, State
Baltimore,	permit. Pages of Department of Hamportent: If ite eny injury or ot once.		Holly Hill Cemetery 11/27/04 Middle River MD  21. Signature of Funeral Service Licensee ( ) 22. Name and Address of Facility Cvach/Rosedale Funeral Home
ğ	Dem Impo		1211 Chesaco AVe Baltimore MD 21237
г			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between
П	Physician		Immediate Cause (Final disease or condition resulting in death)  Onset and Death  Onset and Death
	/Medical Examiner		Due to (or as a consequence of):
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of injury
	scuted ind transit	Examiner	trial initiated events
/60,	ate be executed hysician and the burial-transit	cal Ex	Due to (or as a consequence of):
289	death certificate be executed e attending physician and od for use as the burial-transit		d
Rox	th cert tendin r use	an/M	IF FEMALE: 23b. Was decedent pregnant 23b. If yes, outcome of pregnancy 1
	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	in the past 12 menths?  1
2	law requires that the as been signed by th 2 should be detache	y Ph	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
Records,	w requires been sign should be	ed by	1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown
ပ္ပ ပ	law re as bee 2 sho	ompleted	24a. Was an autopsy findings available prior to completion of cause of
_	: The law cate has page 2 :	Con	performed death?  1   Yes 2   No 1   Yes 2   No
VITAI	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1   Yes   2   No   1   Mospital: 2   EB/Outpatient   3   DOA   Other: 4   Nursing Home   5   Besidence   6   Other (Specify)
	g Phy er this eral d	<b>-</b>	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
0	Attending r death. ector: After by the fune	atlo	2 Accident investigation M 1 Yes 2 No
UNISION	or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
_	To the Hospital or Attending Phys within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral di	al Ce	29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	he Ho n 24 h he Fui	edical	one)  2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	Voith To t	×	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)  D=0056949  29c. License number 29d. Date signed (Month, Day, Year)
	\		2 0030747
	0		30. Name/and address of person who completed cause of death (Item 23a) (Type, Print)  Kamakshi Baig, MD 6620 Crain Hwy Ste 102 La Plata, Maryland 20646
	Sta		31. Date filed (Month, Day, Year) 732. Registrar's Signature
	Registr	ar	NOV 3 0 2004 Beesle & Could

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/200

NOVEMBER

HEGARTY,

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OWEMBER 24, Zear 14 **Physician** 6:00P Flora Marian Barclay Hannan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner OWSON Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 8. Date of Birth | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Director 216-34-7995 Dec. 20,1934 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c, City, Town or Location show 10d. Inside City Limits 7 is marked other then "neturel", or items 23e or 28e-f shot treumstic event, the Medical Event in a tremstice and 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 8133 Delhaven Road 21222 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 Never Married 2 Married TYes 2 ☐ No f Yes, Give 21215-0036 1 ☐ Yes 20XNo Specify: Be Completed by 3 ☐ Widowed 4 ➡ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Bookkeeper Clerical Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill trainent of Health and Mental H tent: If item 27 is marked other. George Barclay, Sr. Mary Hatty Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Linda R. Phillips/Daughter 458 Trappe Road Dundalk, Maryland other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 6 permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 11/29/2004 Towson, Maryland Souture of Funeral Service Lice see 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE **Physician** /Medical Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The taw requires that the death certificate be executed burial-tran Due to (or as a consequence of) attending physician Box 68760 Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Į in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No INTERSTITIAL PULMONARY FIBROSIS 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 XNo 24a Wasan has autopsy certificate 2 1 ☐ Yes No or Attending Physician: Director: After this certification by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Aath 1 XNatural 2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D 30263 'n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHOO, 7601 DRIVE TOWSON, M. D. OSLER MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

			1 - For State Registrar	State of Ma		artment of Hea rtificate of De			711111	37671
			Decedent's Name (First, Middle, La	st)		imouto or bo		Reg. 2. Date of Death	NO.	3. Time of Death
	Physicia /Medic		Petronella There	esa Hirsch	1		N	lovember	24, 2004	9:00 P <sup>M</sup>
}	Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or Loc	cation of Death		4c. County of Death	
			Lorien Frankford			Baltimore	Under 24 Hrs.		N/A	
	Funeral Director		5. Social Security Number 6. S 216 – 20 – 7776	ex I□M 2 X F	(In yrs. last birthday) 78 Yrs.		lours Min.	B. Date of Birth (Month, Day, Ye (1ay 16, 19	ar) Coun	ace (State or Foreign try) /land
	D		Usual Residence of Decedent					10,10,12		
	show	ž	10a. State 10b. County		10c. City, Town or Lo				10	od. Inside City Limits 1 X Yes 2 □ No
	28a-f	Director	Maryland N/A		Baltimo	10f. Zip Code		100	Citizen of What Coun	
	3a or		4611 Frankford	Avenue		,	206	109.	United St	,
	ems 2	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hispar If Yes, specify Cuban, M		ify Yes or No-	14. Race - America	an Indian,
36	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f show than "naturel" or Items 25e or 28e-f show is Maryland at the Maryland at the modified at	by Fu	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🛣 N If Yes, Give	0	V	pecify:	ican, etc.)	Black, White, e	hite
21215-0036	2 hour	edb	15. Decedent's E	Year or Dates:	16a. Dece	dent's Usual Occupation	1	166	. Kind of Business/Ind	
215	hin 72	plet	(Specify only highest gra	completed) College (1-4or 5	(Give	kind of work done durin DO NOT use retired)		7	. , , , , , , , , , , , , , , , , , , ,	2007
21	ygiene ygiene ier the	Completed	8 yrs.			Homemaker			Own Hom	e
Maryland	be fill ntal Hy even	Be	17. Father's Name (First, Middle, Last,			18.		First, Middle, Maid		
Ž	hould id Mer mark matic	<sup>C</sup>	August John  19a. Informant's Name/Relationship (	Hirsch	19h Mailir	ng Address (Street and I	Anna		Rolle	Code
	nd 2 s lith ar 27 is r treu		Marie T. Hirsch		1	1 Frankford		Baltimo		206
J.	ss 1 and of Heal		20a. Method of Disposition		20b. Place of Dispo		Da		. Location - City or Tox	
Ë	Page ment c ent: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specif		1	d Cemetery	11/27/	2004 Ba	altimore, M	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event, If a Mudical Exprision is as I to rectified at one.		21. Signature of Funeral Service Licental	%∾ Michael E	. Canapp 22	2. Name and Address of Leonard J.	1		05 Harford Itimore, MI	
П	*		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not ent					Approximate Interval Between
	Pnysician	H	Immediate Cause (Final disease or condition	a UTE	ZINE CH	MEER				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
		er	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a	consequence of):					
	cate be executed physician and the burial-transit	Examine	cause. Enter Underlying Cause (Disease of injury that initiated events	С.					-0	
90,	cate be executed physician and the burial-transi	EX	resulting in death) Last	Due to (or as a	. consequence of):					
8760,	cate b physic the b	dical		_ d						
9		0	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy				23d. Date of deliver	34
. Box	death certif e attending id for use as	Physician/M	in the past 12 months? 1 □ Yes 2 🕱 No	1□Live birth 2 4□Pregnant at t		Ectopic pregnancy Other (specify)				Day Year
P.0.		hys	9 🗆 Unkлown	9 Unknown						
S,	56 5 90	by	Part II. Other significant conditions of						o use contribute to the	
ord	w require been sig should b	eted	Hyperten sicon;	) /1300)	Konar	majien	y .	1 🗆 Yes	2LXNo 3 Proba	ıbiy 4 ∏Unknown
Rec	0 4 9	Completed						24a. Was an autopsy performed	prior to com	sy findings available pletion of cause of
[a]	icien: Th certificate rector, pag	e Co	25. Was case referred to medical			20	Diagonal Dooth	1□ Yes 2🔀		2 No
Š	Physicien: this certificatal director, I	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatier	t 2 ER/Outpatien		Place of Death		6 □Other (Specify)	
n 0	ng Ph Iter th		27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Injun (Month, Day				d. Describe how in		
Sio	tendir leath. tor: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not be	1		M 1 ☐ Yes	2 No			
Division of Vital Records,	or At after of Direct in by	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, str (Specify)	eet, factory, office	28	f. Location (Street City or Town, St	and Number or Rural ate)	Route Number,
_	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Ph	ysician: To the best o	f my knowledge, death	occurred at the time, da	ate and place, and	d due to the cause	(s) and manner as sta	ted.
	he Ho n 24 h he Fu pletely	edical	(Check only 2 Medical Exam	niner: On the basis of and manner stat	examination and/or inv	estigation, in my opinior	n, death occurred	at the time, date a	and place, and due to	the cause(s)
	with To t	Σ	29b. Signature and title of certifier			29c. License nun			Date signed (Month, D	ay, Year)
,			ROBERT T.			Dair	64	/	1-26-04	
	4		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type,	Print) K S+ L.,	u to il	w 71	) ) \	
	Sta	te	ROBERT LIBERTO 31. Date filed (Month, Day, Year) NOV 3 0 2004	32. Registra	r's Signature	1 2	,010,	7 01	roy	
	Registr	ar	NUV 3 0 2004	Depus	10 /s	porter				

			For State Registrar	State of M	laryland / De	partment of Certificate of		and Menta	al Hygie Reg.			376	72
	Physici	an	1. Decedent's Name (First, Middle, Last)					Mo	te of Death	Day 27 2	Year	3. Time of	
	/Medic	al	Ray Jacobs  4a. Facility Name (If not institution, give:	Sr.	·)	4b. City, Town,	or Location o			4c. County	004	9:10	Дм
	L.Xdiffiii	ICI	Anne Arundel Medic				polis			Anne		de l	
	Funeral		5. Social Security Number 6. Sex 1X	7. A	ge (In yrs. last birtho	Months Davis		Min. 8. Dat	te of Birth onth, Day, Ye IC 24	ar)	9. Birthp	lace (State or	r Foreign
	Director		Usual Residence of Decedent		70			Journ	ie 24 i	934		KY	
	show	-	10a. State 10b. County		10c. City, Town o						1	0d. Inside Cit 1 □ Yes	
	the Ma 28a-f	Director	Maryland Anne Aru	ndel		Pas 10f. Zip Code	adena		100	Citizen of W	hat Cour		- ZAJ140
	h with	ai Di	168 Waldo Road			10.1. E.p 0000	21122	2	log.		SA	у:	
	lams ?	Funerai	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	3. Was Decedent of If Yes, specify Cul	Hispanic Original	gin? (Specify Ye	s or No- etc.)		- Americ	an Indian,	
36	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Medical Examiner must be inclifted at	by Fu	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	3No	1 ☐ Yes 2 ☒ No				Specify:	1.116	ite	
21215-0036	72 hou natura	eted	15. Decedent's Edu (Specify only highest grade	cation	16a. De	ecedent's Usual Occu	pation	t of working	16b	. Kind of Bus	siness/Inc	dustry	
121	within ane. than "	Completed	Elementary/Secondary (0-12)	College (1-4o	·5+)	ive kind of work done e. DO NOT use retin Silk Scre		a. waming		Westi	aaha	100	
d 2	illed Hygie othar ant, u	Be Co	17. Father's Name (First, Middle, Last)			JIIN JOI C		r's Name (First,	Middle, Maid			13E	
ylar	should be filed withind Mental Hygiene. I markad othar than umatic avant, II e M	To B	Harry Jacobs				Lou	ı Emm	ia J	lones			
Maryland	0 0 0 0		19a. Informant's Name/Relationship (Ty			ailing Address (Stree				-	State, Zip	Code)	
	es 1 and 2 of Health fitam 27   r othar tra		Doris E. Jacobs 20a. Method of Disposition	(spous	20b. Place of D	B Waldo Ro sposition (Name of crematory or other pla		Date	20c.	Location - 0	City or To	wn, State	
i i		1	1 ☐ Burial 2 🂢 Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)			rematory I		Dec. 0 2004	b Bal	timore	e, Ma	aryland	d
Baltimore,	permit. Page Department Important: It any injury o		21. Signature of Funecal Service yourse	99		22. Name and Addr		y Sta	llings				P.A.
	÷		23a. Partil. Enter the disease, or compleshock, or heart failure. List only be	cations that cause e cause on each	ed the death. Do not line.	enter the mode of dy	ing, such as	cardiac or respir	atory arrest.	110	2116	Approximate Interval Betw	veen
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		imonia							Onset and D	
	Examiner				s a consequence of):								
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8760,	the death certificate be executed y the attending physician and iched for use as the burial-transit	dicai E		ı			_						
9	entifica ling ph e as th	Medi	IF FEMALE:										
Вох	leath certific attending p	Physician/Me	in the past 12 months?			3 □Ectopic pregnand 5 □ Other (specify)	У			23d. Date Mont		•	'ear
P.O.	that the de ed by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		()/ -							
	es op pe	by	Part II. Other significant conditions cor	tributing to death	but not resulting in th	e underlying cause g	ven in Part I.	236	e. Did tobacc			, ha	eath? Inknown
corc	w requir been si should	leted						244	1 ☐ Yes a. Was an		Probi		
Vital Records,	The tav ate has page 2	Completed	atmentin						autopsy performed	pr de	ior to con ath? Yes	esy findings and pletion of ca	use of
/ital		BeC	25. Was case referred to medical examiner?				26. Place	of Death (Check	Yes 2.74 k only one)	10	7 103	2 140	
of	Phys rthis ral dii	7	1 Yes 2 No	lospital: 1 Appat 28a. Date of Inj		IIBIIL JUDOA		rsing Home 5[	Residence			)	
ion	Attanding I ir death. ector: After by the funer	ation	1 April 2 ☐ Accident 5 ☐ Pending investigation	(Month, D	ay Year) Inju	y Wo	rk? ]Yes 2 □ N		30/100 /104/11	july occurre			
Division	or Attand after death Director:	Certification	3 Suicide 6 Could not be determined	28e. Place of In	njury - At home, farm, tc. (Specify)	street, factory, office			ation (Street or Town, St		or Rural	Route Numb	oer,
	Hospital 4 hours a Funaral E		29a. Certifier 1 Certifying Phys	ician: To the bes	t of my knowledge, d	eath occurred at the t	me, date and	d place, and due	to the cause	(s) and man	ner as sta	nted.	
	To the Hospital or At within 24 hours after of To the Funaral Direct completely filled in by	ledical	one)	ner: On the basis and manner s	of examination and/o tated.	r investigation, in my	opinion, deat	h occurred at the	e time, date a	and place, ar	d due to	the cause(s)	
	To with	Σ	29b. Signature and title of certifier			29c. Licen	se number		29d. [	Date signed	(Month, L	Day, Year)	
•	10		30. Name and address of person who co	mpleted cause of	death (Item 23a) (Tv	De. Print)	1804			1-110	7		
_	U		Robert Polo	1500 1	dodin (nem 25a) (ry	AAMC	/	tunope	dis 1	Ucf	21	401	
:	Sta Registr		31. Date filed (Month, Day, Year) NOV 3 0 20	32. Regis	rar's Signature	29c. Licen D 2 De, Print) A M C							

			1 - For State Registrar	State of	Marylaı	nd / Depa <i>Cei</i>	artment rtificate	t of H e <i>of L</i>	lealth a D <i>eath</i>	and M		giene Reg. No		4	37673	
	Physici	an.	1. Decedent's Name (First, Middle, Last)		-						2. Date of Dea		v	Year	3. Time of Death	
	/Medic		ALVINUS JOHNSON								NOVEMBI	ER 2	3 2	004	7:00 P	М
	Examir	er	4a. Facility Name (If not institution, give : FREDERICK MEMORIA)						Location o	of Death			. County o			
			5. Social Security Number 6. Sex			. last birthday)	FRED:		If Under:	24 Hrs	8. Date of Birt		REDE			
	Funeral Director			\$M 2□F	75	Yrs.	Months	Days	Hours	Min.	(Month, Day	Vear	929	Coun		Эn
h			Usual Residence of Decedent								OCL. I	2 9 1.	727	ive.	Jersey	-
	how		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10	Od. Inside City Limit	s
	Ba-f s	cto	VA Loudoun			Leesbur	g								1 X Yes 2 □ N	0
	vith th	Director	10e. Street and Number				10f. Zip	Code				10g. Cit Un:	izen of W ited	hat Coun Stat	try?	
	s 238	ral	20530 Norman Plac			10			175			E	Ameri	ca		
	item item	Funeral	11. Marital Status 1 ☐ Never Married 2X Married	<ol> <li>Was Decede Armed Force</li> <li>Yes 2</li> </ol>	es?	J.S. 13. V	Nas Deced f Yes, sp <i>ec</i>	ent of Hi ify Cuba	spanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		14. Race Black	- America , White, e		
99	urs af	b	3 Widowed 4 Divorced	If Yes, Give Year or Date	_		1□ Yes 2	No No	Specify:				Specify:	Whi	te	
21215-0036	within 72 hours after death with the Maryland ane than "natural", or items 23a or 28a-f show ha Madical Exama ar must be routified at	Completed	15. Decedent's Edu	cation	***** 1	16a. Deced	lent's Usua	l Occupa	ation	A = 6 del		16b. K	ind of Bus			
2	e. e. Med	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4	or 5+)	Experi	kind of wor DONOTUS MENUS	PIE ired	luring mosi Ligh	t or worki	ng	Uni	ited			
7	filed wi Hygien other th	Con		5+		Τe	st Pi	11ot					Mili			
ng Pu	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)	T 1							(First, Middle,			•		
Maryland	should be ind Mental marked o	L C	Alvinus Percival  19a. Informant's Name/Relationship (Ty,		1	10h Maille		(04			E1eano					
S	C1 00 00 00		Anne W. Johnson				Norn				Route Numbe		2017		Code)	
ā,	of Health item 27		20a. Method of Disposition	(WIIC)	20b.	Place of Dispo					espurg,		cation - C		wn, State	
more,	Pages nent of I int; if its iry or o		1 ☐ Burial 2 🖾 Stremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta		cemetery, cren tropoli				11	/27/04			•		
alti	permit. Pages Department of Important; If I any injury or a	l (í	21. Signature of Funeral Service License	9	#CCO					y Co	lonial	Fune	ral	Home	IISIIIIa	-
ñ	Per Suppose		Maray J. I	2010	te						Rd.NE				20176	
	.*		23a. Part 1. Enter the liseage or compli	cations that cau	sed the dea	th. Do not ente	er the mode	of dying	g, such as	cardiac e	respiratory ar	rest,		11	Approximate Interval Between	
	Physician	i n	Immediate Cause Final disease or condition	11/3	Ros	me	Di	ala.	217					/	Onset and Death	
	/Medical Examiner		resulting in death)	Due to@	s a conse	quence of):	0-70-							-	Tyre -	
	Examiner	_	Sequentially list conditions, if any, leading to immediate													
	ed	niner	r any, leading to immediate rause. Enter Underlying Cause (Disease or injury	Due to (or	as a consec	quence or):										
	and al-trai	Examin	that initiated events resulting in death) Last	Due to (or	as a conse	quence of);							_	-		_
8760	cate be executed physician and the burial-transit	dical E														
89	ifficati g phy as the	edic										-10				
Box	death certifi e attending p id for use as	Physiclan/Me	230. Was decedent pregnant	3c. If yes, outcor 1 ☐ Live birth			Ectopic pre					:	23d. Date	of deliver	у	
	0 0 0	sicle	in the past 12 months? 1 Yes 2 No	4☐Pregnan 9☐Unknow	t at time of o		Other (spe					ľ	Mont	h l	Day Year	
о. О	at the de 1 by the etached	Phy	9 Unknown					-		-						
ທົ	The law requires that the te has been signed by th bage 2 should be detache	by	Part II. Other significant conditions con	tributing to deat	h but not res	sulting in the ur	iderlying ca	iuse give	n in Part I.				e la		cause of death?	
0	w require	eted									1 □ Y	es 2	No 3	Proba	bly 4 Dnknow	1
Records,	e 2 sl	Completed									24a. Was a autops	sy	24b. We	ere autop or to com	sy findings available pletion of cause of	8
											perfor	med? 2 No		ath?	No	
Vital	Physician: this certific ral director,	Be c	25. Was case referred to medical examiner?	ospital:				Othe			(Check only or					
ō	hy his	- To	1 Yes 2 No	ospital: Inpa		ER/Outpatient 28b. Time of		Sc. Injury	" 4 🗌 Nur		ne 5 Reside					
o	ding f th. After funer	tlor	1 Natural 5 ☐ Pending investigation		Day Year)	Injury	М	Work	?` ′es 2 ☐ N		.00. 5000.50 ;;	011 111101	, 00001100	•		
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	s afte	Certification;	4   Hollicide	building,	etc. (Speci	<i>Ty)</i>					City or Tow	n, State,	)			
	e Kospital or Attending P 24 hours after death. • Funeral Director, After t etely filled in by the funera		29a. Certifier (Check only  Medical Examin	ician: To the be	st of my kno	owledge, death	occurred a	t the tim	e, date and	place, a	nd due to the c	ause(s)	and man	ner as sta	ted.	
	To the Hospital or A within 24 hours after to the Funeral Directompletely filled in by	<b>ledical</b>	one)	and manner	stated.	ation and/or inv				- OCCURR						
	To To corr	Σ	29b. Signature and title of certifier	Kart			29c.	License	number		2	9d. Dat	e signed (	Month, D	ay, Year)	
	$\bigcap$		Voluly . 1	1	w		10	-/-	07/			11/0	24/	04		
	4		30. Name a address of person who co	No. Acc			•	+ -		T	M- "	-	01-	0.1		
30	Sta	te	31. Date filed (Month, Day, Year)		strar's Signa		orree	C F	rede	rick	, Maryla	and	217	ΩT_		_
	Registr	3	WINNESS D. COOL	. A	موالسعماري	B	100	Ms	1							

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			1 - For State Registrar	State of Marylar	nd / Departi <i>Certif</i>	ment of H icate of I	lealth and I Death	Mental Hy	giere 0	04	37674
	Physic /Medi		Decedent's Name (First, Middle, Last,     PAUL D. JOYNER	)				2. Date of De Month		Year	3. Time of Death 7:20 M
	Examir Funeral Director		221 10 3031 31	Hospital	last birthday) If		Location of Death 3 Unie If Under 24 Hrs. Hours Min.	8. Date of Bi	An	9. Birthp	rundel place (State or Foreign L'AND
	the Maryland 28a-f ahow collified at	ector	Usual Residence of Decedent		ty, Town or Location				10g. Citizen o		10d. Inside City Limits
036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It has the marked other than "natural", or items 23a or 28a-1 ahow item 27 is marked other than "natural", or items 23a or 28a-1 ahow other traumatic event, the Medical Examinat must be notified at	by Funeral Director	51 GLEN RIDGE R  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	D. APT B1  12. Was Decedent Ever in U Amped Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:	I.S. 13. Was	2106	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	USA	A Race - Americ Black, White,	ean Indian, etc.
ld 21215-0036	should be filed within 72 ho and Mental Hygiene. s marked other then "naturi numatic event, the Medical I	Be Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) -12- 17. Father's Name (First, Middle, Last)		life. DO I	's Usual Occupa of of work done o NOT use retired	turina most of wor		TA	Business/Ind AXI CA	
Maryland	and 2 should be ealth and Mental n 27 is marked er traumatic ev	ToB	SONNY UPSHUR  19a. Informant's Name/Relationship (7) DIANNE JOYNER (WI		61		ROSA		er, City or Tow		•
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition  1 X Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	20b. Removal from State	Place of Disposition cemetery, cremato WNSVILLE	n (Name of ry or other place VETERA	ns 11-2	Date 2-2004	20c. Location	n - City or To	
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68760,	cate be executed physician and physician and the burial-transit the burial-transit case.	dical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate ease. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence).	juence of):  LATURY  juence of):  LETE  juence of):	I FA	ilure T glo				Interval Between Onset and Death
.O. Box (	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as I	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of degree of the second second second second second second second second second second second second second second second second second sec	Il death 3 □Ect	opic pregnancy ner (specify)		.*		Date of delive Month	ory Day Year
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Division of Vital	or Attending Physier death. Irector: After this In by the funeral dia	Certification; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Mann Death  1 atural 5 Pending investigation  3 Suicide 6 Could not be determined	dospital: 1 Impatient 2 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At h. building, etc. (Specif	28b. Time of Injury		at Nursing H	ome 5 Resi 28d. Describe	dence 6 00 how injury occi	urred	/) I Route Number,
u	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical Ce	29a. Certifier (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occ tition and/or investi	curred at the tim gation, in my op	e, date and place, inion, death occur	and due to the red at the time,	cause(s) and r date and place	manner as sta e, and due to	ated. the cause(s)
	To the comp	M	29b. Signature and title of certifier  30. Name and address of person who co		n 23a) (Type, Print	29c. License  0003	15703		29d. Date sign	14/0 Ver	Day, Year)
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	404 C	due e	nsbur	4 ISO	M	d. 2	0730

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Physic	ian	1. Decedent's Nam	TEND TIEM  ne (First, Middle, Las.  HENRY JEN	)	rn Gooy (La	<i>ampanen</i>	Deam	2. Date of Dea Month	Day	Year 3. Tim	675
_/Med			If not institution, give			4h City Town	or Location of Death	NOVEMB	4c. County of		30 P. M
Exami	ner		LAND HEALT				ERRY POINT	п		CECIL	
Funera Director		5. Social Security I	Number 6. Se		e (In yrs. last birthday, 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birtl (Month, Da) 5-30-1		9. Birthplace (Sta Country) MARYLAN	te or Foreign
pu		Usual Residence of 10a. State	of Decedent 10b. County		10c. City, Town or L	ncation				10d Incide	e City Limits
Marylan a-f show iffed at	tor	MD.	ANNE ARU	NDEL	SEVERN.						res 2 ☐ No
vith the Mi or 28a-1 be notifie	Director	10e. Street and Nu			DD.	10f. Zip Code			10g. Citizen of W	hat Country?	
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ire, INIALYIATIO ZIZID-UUJO s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinal must be notified at	by Funeral	11. Marital Status 1 X Never Mar 3 □ Widowed	ried 2 Married	Armed Forces?  1 X Yes 2 If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	веслу Yes or No- Alcan, etc.)		- American Indian c, White, etc. BLACK	1,
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parimore, Maryianu Zizi permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than any injury or other traumatic event, tha My once.	BeC	17. Father's Name	(First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumame	)	
uld b Menta Menta rrked	To	JAMES	H. JENNI	NGS			ANNIE	G. SPEN	CE		
and and ls ma		19a. Informant's N	lame/Relationship (T	үрө, Print)	19b. Maili	RTICHIE	t and Number or Rui	al Route Numbe	r, City or Town, S	State, Zip Code)	
and 2: sealth as m 27 is her trau			O. JENNIN	GS(SON)	325.	LITTLICE					
Dallinole,  bermit. Pages 1 an  bepartment of Heal  mportant: If Item 2  iny injury or other  nnee.		20a. Method of Dis	sposition   Cremation 3	Removal from State		matory or other pla	ice)	Date		City or Town, State	
tmen tant:			5 Other (Specify				RANS 11-23	the second second second		LLE, MAR	
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eath cer attendir for use	by Physician/Medical	IF FEMALE: 23b. Was deceded in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	23c. If yes, outcome  1 Live birth  4 Pregnant a'  9 Unknown	2 Fetal death 3	Ectopic pregnanc	у		23d. Date Mont	of delivery th Day	Year
uires that uires that signed b	d by PI	Part II. Other signi	ificant conditions co	ntributing to death b	ut not resulting in the u	inderlying cause gr	ven in Part I.			oute to the cause of	
or Attending Physician: The law requires that the dafter death. Director: After this certificate has been signed by the lin by the tuneral director, page 2 should be detached	Completed			***				24a. Was a autops perform	med?   de	ere autopsy findin ior to completion o ath?	gs available of cause of
vician: The certificate rector, pag	Be C	25. Was case refe	-				26. Place of Deat	h (Check only or	ne)		
ding Physic After this ce funeral dire	2	1 Yes 2 2	VAO	1 X Inpatie 28a. Date of Inju (Month, Da		f 28c. Inju Wo	her: 4 ☐ Nursing Hory at rk?		ence 6 Other		
or Attendi	Certification:	2 Accident 3 Suicide 4 Homicide	investigation 6  Could not be determined	28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)		]Yes 2□No	28f. Location (Si City or Town	treet and Number n, State)	r or Rural Route N	lumber,
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Ce	29a. Certifier (Check only one)	XX Certifying Phy 2 Medical Exam	sician: To the best iner: On the basis o and manner st	of my knowledge, deat f examination and/or in ated.	h occurred at the ti vestigation, in my	me, date and place, opinion, death occur	and due to the cred at the time, d	ause(s) and man ate and place, ar	ner as stated.	Θ(S)
To the vithin To the omple	Me	29b. Signature and	title of certifier	. 1		29c. Licens	se number	2	9d. Date signed	(Month, Day, Year	r)
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, ,			1 - For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment o rtificate	of Hea of De	lth and <i>ath</i>	Mental Hy	/giene 0	4	37676	
	Physic /Medi		1. Decedent's Name <i>(First, Middle, Last</i> Susan Jensen	)					2. Date of D Month Novemb	eath Oay OCT 25,	2004	3. Time of Death	vI
	Exami		4a. Facility Name (If not institution, give Harbor Hospital			4b. City, Too Balti	imore			4c. Count	'A		
	Funeral Director		5. Social Security Number 6. Se 212-58-1715	X 7. Age (In yr.	s. last birthday) 69 Yrs.	If Under 1 \ Months D		Jnder 24 Hrs ours Min		1, 1935	9. Birthp Coun Penr	lace (State or Foreig try) 1a •	חן
	he Maryland 28a-f show officed at	Director	10a. State 10b. County  Maryland N/A	10c. C	Baltimo	ore						0d. Inside City Limits 1 X Yes 2 □ No	
	th with 1 23e or 3	al Dir	1 West Conway Stre	eet		10f. Zip Co	.230			10g. Citizen of USA	What Coun	try?	
920	be filed within 72 hours after death with the Maryland hal Hygiene. ad other than "natural", or Itams 23e or 28a-f show event. I've Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates:		Was Decedent f Yes, specify 1 ☐ Yes 2 🔯		nic Origin? (Sexican, Puer	Specify Yes or N to Rican, etc.)		ce - Americ ck, White, e y: Whit	etc.	
21215-0	e filed within 72 ho al Hygiene. I other than "natu vent, I'm Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation le completed) College (1-4or 5+)	(Give	dent's Usual O kind of work o DO NOT use n NESSWOIT	lone during etired)	g most of wo	rking	16b. Kind of B			
yland	2 should be filed and Mental Hygid Is marked other aumatic event.	To Be C	17. Father's Name (First, Middle, Last)  Jen T. Jensen				E	lizabe	th McMo				
Baltimore, Maryland 21215-0036	es 1 and of Health fitem 27 rother tr		James Whittman, So  20a. Method of Disposition  1 Burial 2 MCremation 3 F  4 Donation 5 Other (Specify)	On 20b.		South sition (Name of	Char of place)	les St		20c. Location	Mary City or To	land 2123	3C
Baltii	permit. Pag Department Important: f any injury o		21. Signature of Funeral Services John Thomas Gregor		22	Name and A	ddress of I	Facility		yland Ir more, Ma			
8760,	death certificate be executed  Wedical  Example  A for use as the burial-transit	dical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to it mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)	iquence of):	nere	HSDATT	16 LV	VG CAV	CLINDH!	+	Interval Between Onset and Death	
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<u>α</u> ,	og og	by	Part II. Other significant conditions cor	ntributing to death but not re	sulting in the ur	iderlying cause	e given in f	Part I.		obacco use cont		cause of death?	_
tal Records,		Completed	25. Was each referred to medical						1 Yes	ormed?	prior to com death?	sy findings available pletion of cause of	,
ion of Vital	ig Physter this neral di	ation: To Be	25. Was case referred to medical examiner?  XYes 2 No  27. Manner of Death  1 Matural 5 Pending investigation	lospital: 1 lnpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c.	0.1	□ Nursing H		dence 6 Oth			
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At t building, etc. (Special	nome, farm, stre	eet, factory, off	ice		28f. Location (- City or To	Street and Numb wn, State)	er or Rural	Route Number,	
	To tha Hospital or within 24 hours after To tha Funerel Dir completely filled in	Medical	29a. Certifier 1 Certifying Physical Componer 1 Certifying Physical Examination (Check only one)	sicien: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the estigation, in r	e time, da ny opinion	te and place , death occu	, and due to the rred at the time,	cause(s) and ma date and place, a	nner as sta and due to t	ted. he cause(s)	
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier	•			ense num			29d. Date signed			
/			13/071	mpleted cause of death (Ite			Stree	t, Bal	timore,	Marylar			
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 3 0	32. Registrar's Sign		h So	acks						

State of Maryland / Department of Health and Mental Hygiere 37677 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year WALTER WILLIAM JERSCHEID 9:50 A NOVEMBER 26 2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death LORIEN NURSING HOME - FRANKFORD BALTIMORE N/A 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7 Ane (In vrs. last hirthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 214-38-3098 64 Director 7-21-1940 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other traumatic event, the Madical Examiner must be notified at MD Baltimore 1 ☐ Yes 2 X No Director Reistertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Saloney Ct. or items 23a 21136 Completed by Funeral USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 ☐ Widowed 4 ☐ Divorced natural', 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if itam 27 is marked othar than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Λ Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter William Jerscheid Sr. Dorothy Mae (Disharoon) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Jerscheid/Brother 8041 Edgewater Ave Rosedale MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it. 1 Burial 2 Cremation 3 Removal from State Metro Crematory 11/30/2004 <sup>4</sup> □ Donation 5 □ Other (Specify) Baltimore MD 22. Name and Address of Facility Cvach/Rosedale Funeral Home Signature of Euneral Service Licensee DICE. 1211 Chesaco Ave Baltimore MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** sonhagea resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a nonsequence of): burial-transit or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy õ in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) P.O. ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2 🗆 No 1 Yes 2 ZKNo 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4-Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification; To 1 ☐ Yes 2 ≥ No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1/54Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29104 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neck Ru Raltimor 2112 31. Date filed (Month, Day, Year) 201-101 arer 32° Registrar's Signature State NOV 3 0 2004 Registrar

			1 - For State Registrar	State of	Maryland / De <i>C</i>	partment of ertificate of	Health a f <i>Death</i>	ınd Me		iene 0 (	14	37678
	Physic	ion	1. Decedent's Name (First, Middle, L	,				2	. Date of Deat Month			3. Time of Death
	/Medi		Donnie Johnson	M				)	Jovenbei	Day 25, 20	Year 2004	300 A M
	Exami	ner	4a. Facility Name (If not institution, gi		er)	4b. City, Town,				4c. County of		
			Northwest Hospita	ai contev			11s town			Balt	imo	re
	Funeral		, , , , ,	Sex 7. 1 □ M 2 <b>X</b> XF	Age (In yrs. last birthda	y) If Under 1 Yea Months Day		24 Hrs. 8. Min.	Date of Birth (Month, Day, 2-22-1		9. Birth	place (State or Foreign
	Director		217-10-5293	I M ZEF	81 Yrs.		710013		2-22-1	923	COU	AL
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location						
	faryla eho	5										10d. Inside City Limits 1 X Yes 2 □ No
	788-1	ect	MD 10e. Street and Number		BALTI							
	with	Dir		1112		10f. Zip Code	007		10	0g. Citizen of W	hat Cou	ntry?
	e 23	Funeral Director	5504 WINTON AVEN		-15 : U.S. Tu		207			USA		
	lter d	Ľ.	11. Marital Status  1 □ Never Married 2 🕅 Married	12. Was Decede	s?	<ul> <li>Was Decedent of If Yes, specify Cu</li> </ul>	Hispanic Orig ban, Mexican,	in? (Specif Puerto Ric	y Yes or No- an, etc.)		- Americ , White,	ean Indian, etc.
36	I's af		3 Widowed 4 Divorced	1 □ Yes 2 If Yes, Give Year or Date		1 ☐ Yes 2 XN	Specify:			Specify:	DI	A 077
21215-0036	72 hours after death with the Maryland natural', or Iteme 23a or 28a-f ehow dical Examinat must be notified at	Completed by	15. Decedent's 8			edent's Usual Occi	ination			10h Kind of D.		ACK
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212	I within piene.	mo	Elementary/Secondary (0-12)	College (1-4	'	OMEMAKER				HOME	7	
b	ba filed within 72 hours after death with the Marylan nat Hygiene. Id other than "natural", or feme 23a or 28a-f ehow event, the Medical Exaginat must be notified at	Bec	17. Father's Name (First, Middle, Las	t)			18. Mother	's Nam <i>e (F</i>	irst, Middle, N	faiden Sumame		
Maryland	should ba nd Mental markad o imatic eve	ToB	HURIE GRANGER						NDERSON			
ary	S D E E	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	ling Address (Stree					tate. Zio	Code)
	1 and 2 Health a tem 27 le	1	RENEE HARRIS/DAU	GHTER	18	WINDY ME	ADOW C	Γ. RAI	NDALLST	TOWN, MI	2	1133
ē,	s 1 ar		20a. Method of Disposition		20b. Place of Disp	position (Name of	neal .	Date	2	20c. Location - C	ity or To	own, State
Ë	Pages nent of I int: If its iry or o		1   Burial 2 □ Cremation 3   Comparison 5 □ Other (Special Compar		ite i	ematory`or other pl MEMORIAL	* F	11-30-	-04	BALTIM	(ODE	MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice									F.H., INC.
ä	Der Jung		Dames (	a m	notino!	1701-31				MORE, M		21217
			23a. Part1. Enter the disease, or con	plications that cau	sed the death. Do not e	nter the mode of dy	ing, such as ca	ardiac or re				Approximate
	Priysician		Immediate Cause (Final	one cause on each	vorme.							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		as a consequence of):						-	
	Examiner				as a consequence or,							
	- 1545	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a consequence of):						-	
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	rtifica ng ph as th	led	Te service			_					İ	
Вох	death certifi e attending d for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor		□Estable areanan				23d. Date	of delive	ry
Э.	dea ne att	sicle	in the past 12 months? 1 🗆 Yes 2 🗷 No		at time of death 5	□Ectopic pregnanc □ Other (specify) _	-у			Month	1	Day Year
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Ś	Tha law requires that ste has been signad b page 2 should be deta	by F	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause g	ven in Part I.		23e. Did toba	acco use contrib	ute to th	e cause of death?
ב	v requir been s should		dementia	·				_	1 🗌 Yes	2 □ No 3	☐ Proba	ably 4 Unknown
Records,	a law r has be le 2 sh	ple							24a. Was an	24b. We	re autop	sy findings available
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Vital	Attending Physician: Th r death. actor: After this certificate by the funaral director, pag	Be	25. Was case referred to medical examiner?				26. Place o		heck only one		1103	-
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n of	ding Ph h. After th funaral		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Ir (Month, I	njury 28b. Time ( Da <i>y Year</i> ) Injury	of 28c. Inju	ry at			injury occurred		
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	/Medic	al		t not institution air	ye street and number			4b. City, Tow	n. or Locati	on of Death	Copa	by al	County of E	-	08:04 AM
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	land ow		Usual Residence of 10a. State	10b. County		10c. Cit	ty, Town or Lo	cation						10	Od. Inside City Limits
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	or 28	Dire	10e. Street and Nur		,			10f. Zip Cod		200		10g. Cit	izen of Wha	t Coun	try? USA
	ns 23s	Funeral Director	3/04 BI	RETON WAY	12. Was Deceder	it Ever in U	.S. 13.	Was Decedent		.208 Origin? (Spe	cify Yes or No	)-	14. Race - A	Americ	
2	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Menlart Hygene. f Health and Menlart Hygene. other is merked other then, "natural," or items 23a or 28e-f show other treumatic event, it e Modical Examination notified a	by		ied 2(X) Married 4 □ Divorced	Armed Forces 1 N Yes 2 If Yes, Give Year or Dates	s? ] No		fYes, specify 0 1 ☐ Yes 2 🔀 1			Rican, etc.)		Black, V Specify:	Vhite, e	etc. WHITE
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	the deg	ysic	1 ☐ Yes 2 € 9 ☐ Unknown	□No	4⊡Pregnant 9□Unknown	at time of d	leath 5	Other (specify	")						
, ,	s that ined by e deta	by Ph	Part II. Other signif	ficant conditions	contributing to death	but not res	ulting in the u	nderlying cause	given in Pa	art I.	23e. Did t	obacco u	se contribut	e to th	e cause of death?
Š	equire en sig ould b										10	Yes 2	□ No 3 □	] Proba	ably 400nknown
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<u> </u>	ttendi death. stor: A	icati	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be	oe Ogo Place of I	niunt - At h	ome farm str	eet, factory, offi	Yes 2		28f Location /	Street an	d Number o	r Rural	Route Number,
2	after after I Direct	Certification;	4  Homicide	determined		etc. (Specif		eet, lactory, on	Ce	-	City or To			710727	rioble riumber,
	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours atterdeath. Within 24 hours atterdeath. To the Funeriel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	edical C	29a. Certifier (Check only one)	Certifying P	hysician: To the bes miner: On the basis and manner:	of examina	owledge, death	occurred at the vestigation, in m	e time, date ny opinion, d	and place, a death occurre	and due to the ed at the time,	cause(s) date and	and manne place, and	r as sta due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and	title of certifier	your	20			ense numb				e signed (M		
			Com	mkor	Jus		,	HC	) دوس	544		Uare	mber	<u></u>	0 2004
	B		30. Name and addr		completed cause of	death (Item	n 23a) (Type,	Print) Ceaazt	Pood	Ran	dallsto	الم	MD	2	= 2004 1133
	•			th, Day, Year)	an Desi	trar's Signa	tura &	Soon							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#29a, perfff, 11/30/04 6837, TI

State of Maryland / Department of Health and Mental Hygiere O. I. 37680 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician :24 PM 102Or November 2004 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medical Baltimore 20 I timore a N/A 6. Sex 14 M 2 □ F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 01/06/1934 5. Social Security Number **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Min. 213-30-0071 70 Director MD Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Eraniner must be notified at 1 Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? E. 32 ND STREET 21218 U.S.A. or Items 23a #810 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Specify: WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", any njury or other traumatic event, the Medical Exa once. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) EXECUTIVE INTERIOR DESIGN 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Be NELSON **JACOBSON** 2 BESSIE MAZOR 19a. Informant's Name/Relationship (Type, Print) SISTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSELLEN FLEISHMAN DAUGHTER 6 OAK HOLLOW COURT BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) HEBREW FRIENDSHIP 11/28/2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): **Examiner** tailure Sequentially list conditions, if any, leading to immediate and cause (Disease or injury that initiated events resulting in death) Last senal Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Diabetes attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 10 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 ☐ Yes 2 € No 1 Impatient Certification: To 3□ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After t 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No s after death. 2 Accident filled in by the 6 ☐ Could not be 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD, PNI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 3 0 2004 Registrar

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		-	1 - For State of Maryland /	Department of Health and M Certificate of Death		ene 9. N <b>2</b> 0 0 4	37681				
	Physici		1. Decedent's Name (First, Middle, Last)  Robert Kim		2. Date of Death Month	Day Year 24 2004	3. Time of Death				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1				
			10244 Red Lion Tavern Court.  5. Social Security Number 6. Sex 7. Age (In yrs. last I	Ellicott City  birthday) If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	Howard	lace (State or Foreign				
	Funeral Director		213.23.7579	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 12–11–19	Year) Coun	Lmore, Md				
	D		Usual Residence of Decedent								
	with the Maryland le or 28a-f show Les notified at	ò		wn or Location icott City		1	0d. Inside City Limits 1 ☐ Yes 2√2 No				
	the N	rect	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun					
	3e or	DI	10244 Red Lion Tavern Court.	21042		USA	,				
36	72 hours after death with the Marylan "natural", or Items 23e or 28a-f show idical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: As:					
5-0036	"natural",	eted	15. Decedent's Education 16 (Specify only highest grade completed)	ia. Decedent's Usual Occupation (Give kind of work done during most of work)	ina 1	6b. Kind of Business/Inc	dustry				
2121		Completed	Elementary/Secondary (0·12) College (1-4or 5+)	life. DO NOT use retired)		Chardent					
12	2 should be filed withir and Mental Hygiene. Ie marked other than eumatic event, 116 M.	e Co	9th 17. Father's Name (First, Middle, Last)	Student 18. Mother's Name		Student  aiden Sumame)					
Maryland	ld be fental if	To Be	Jong Wook Kim		In Ok Byun						
ary	shoul and M e mari	-	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Rura	al Route Number,	City or Town, State, Zip	Code)				
	s 1 and 2 of Health a item 27 ls r other tre			0244 Red Lion Tavern (							
altimore,	Pages 1 and 2 should be filed withir ent of Health and Mental Hygiene. nt: If item 27 le marked other than ry or other treumatic event, the Mery or other treumatic event, the Mery or other treumatic event, the Mery or other treumatic event, the Mery or other treumatic event, the Mery or other treumatic event, the Mery or other treumatic event, the Mery or other treumatic event, the Mery or other treumatic event, the Mery or other treumatic event, the Mery or other treumatic events are events.		Mulburial 2 Ucternation 3 Premoval from State	of Disposition (Name of tery, crematory or other place)  wridge Mem.Pk.Ic.11/26		oc. Location - City or To Elkridge, M					
Balti	permit. Pages Department of Importent: If I any Injury or once.		21. Signature of Funeral Service Licensee  MS. Hadman	22. Name and Address of Facility Gar Mem. Pk. Inc. 7250 W	v L. Kau	ifman F/H @	Meadowrida				
8760,	Physician /Medical Examiner	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21U/5 shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
O. Box 6	death certific e attending p d for use as l	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	th 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ery Day Year				
ds, P	90 00 00	by	Part II. Other significant conditions contributing to death but not resulting Pa/54	g in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?				
Division of Vital Records,	efaw hasb je 2 sl	Completed	7		24a. Was an autopsy perform	24b. Were auto prior to cor death?	psy findings available inpletion of cause of				
ita		Bec	25. Was case referred to medical examiner?	26. Place of Death							
) t	d is	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/d			nce 6 Other (Specify	()				
uc Ou	After After tune	tlon	1 Natural 5 Pending (Month, Day Year)	D. Time of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe hov	v injury occurred					
ivisi	or Attending tter death. irector: After n by the tune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,				
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical Ce	29a. Certifier (Check only 2   Medical Examiner: On the basis of examination								
	the h	Medi	one) and manner stated.	29c License number	29	d. Date signed (Month,					
	T wit		Delexander Whom J.	MD D36230		11/24/04	/				
	1		30. Name and address of person who completed cause of death (Item 23a 237 North Broadway	Baltimure	MD Z	1205					
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature (Month) 2004	and/or investigation, in my opinion, death occurred by Sec. License number D36230  a) (Type, Print)  Apauls  Apauls							

State of Maryland / Department of Health and Mental Hygie 2004 1 - For State Registrer 37682 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Kenneth Koller 2:30 PM 22 Nov. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 603 Rowe Drive Aberdeen Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2□ F Director 63 MD 214-36-7730 March 16, 1941 Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland hent of Health and Mental Hygiene. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits ral, or items 23s or 28a-f show Examiner was be cutilled at MD Harford 1 ☐ Yes 2 No Aberdeen Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 603 Rowe Dr. 21001 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 →Yes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed the Madical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than. Elementary/Secondary (0-12) College (1-4or 5+) 12 +<u>Logistics Specialist</u> Dept. of Army is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edgar M. Koller 2 Susannah Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trat once. Anita L. Koller/Wife 603 Rowe Drive, Aberdeen, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Bayview Crematory 11/26/2004 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir, Inc., 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of) Due to (o **Examiner** sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MOMIC Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed rearo Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Periknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan Dumon autopsy page certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Que Have de gree 40 siens S. NAIR, MD KARMACHANDRA. 601. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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			1 - For State Registrar	State of Ma	aryland / Do	epartmen					iene	ogibio.	0 7	C O O
			Decedent's Name (First, Middle, L.	.ast)						2. Date of Deat	h Ct	<del>) U 4</del>	3. Time	of Death
	Physicia		Rachae1	Ilene	Knoll					Novembe	r 23,	2004	6:3	30pm <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, g			4b. City,	Town, or	Location of	of Death			ounty of Death		
			Kernan Hospita	L		В	alti	more				Balti	more	
	Funeral		Social Security Number 6.		e (In yrs. last birth	Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	Cour	lace (Sta	te or Foreign
	Director		307-46-7449	1□M 2 <b>X</b> F	61 Y	rs.		110010		Jan. 4,	1943	3 In	díana	a
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						1	Od. Inside	e City Limits
	sho	ō												es 2X No
	28a-1	ect	Maryland Anne 10e. Street and Number	Arundel	]G	ambrill 101. Zip				1	0a. Citizer	n of What Cour	ntrv?	
	with Sa or			n Drivo				.054				ited St		
	ns 20	Funeral Director	1518 Sappington	12. Was Decedent	Ever in U.S.	13. Was Deced			gin? (Sp	ecify Yes or No- Rican, etc.)		Race - Americ	an Indian	1,
ယ	or Iter	표	1 Never Married 2 Married	Armed Forces?	No				n, Puerto	Rican, etc.)		Black, White,	etc.	
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21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-f show ha Medical Examinar must be notified at	Completed	15. Decedent's (Specify only highest of	Education grade completed)	(	ecedent's Usua Give kind of wor	rk done d	durina mosi	t of work	ing	16b. Kind	of Business/Inc	dustry	
21	ithin nan 	ďш	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT us		1)						
2	lled w tygiei her tl		17. Father's Name (First, Middle, La	4 yr		Homema	.ker	19 Mothe	ar's Name	e (First, Middle, I		n Home		
anc	ntal H ad ot ad ot	Be								beth	Wood			
Maryland	hould d Me mark matic	10	Dean Brow  19a. Informant's Name/Relationship		19b. /	Mailing Address	/Street a			al Route Number			Code)	
<u>8</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Archart: If item 27 is marked other than "natural; or liems 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		Jerry L. Knoll/			8 Sappi				Gambri1		7-20		054
<u>6</u>	f Hea f Hea itam othan		20a. Method of Disposition		20b. Place of D	Disposition (Name of the Community of th	ne of					tion - City or To		
Baltimore,	Page ent o nt: If ry or		1 ☐ Burial 2X☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe			•		. 1	11/	30/2004	Oder	aton M	arv1	and
盖	neit. Joertm Sortan 7 inju		21. Signature of Funeral Service Lic		MCSC AI	22. Name an	d Addres	ss of Facilit	ty 1 1	Home & C		barra D	A .	ana
m	Departing any ir		Juanto (RY	Romes M	100957	1/11 A	.SOII	runer	BO3	d Odent	on N	darylan	.A.	112
Æ			23a. Parill Enter the disease, or co shoot, or heart failure. List on	mplications that caused	the death. Do no	ot enter the mod	e of dyin	g, such as	cardiac	or respiratory arre	est,	alyre	Approxi	mate Between
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×	death certifica e attending ph id for use as th	/We	IF FEMALE:	23c. If yes, outcome	of pregnancy						23d	d. Date of delive	arv	
Вох	atter I for u	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 反 No	1□Live birth 4□Pregnant a	2 Fetal death time of death	3 ☐ Ectopic pr 5 ☐ Other (sp		'				Month	Day	Year
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ğ	w require been sig should b									1 □ Ye	s 2 🖎	No 3 ☐ Prob	ably 4	Unknown
O O	e law requ has been je 2 shoul	ompleted								24a. Was a autops		24b. Were auto	psy findin	igs available of cause of
Vital Record	9 4 9	E								perform	nad? 2 X No	death?	2 <b>X</b> No	5, 54455 5,
ita	illic in	BeC	25. Was case referred to medical examiner?		· · · · · · · · · · · · · · · · · · ·					h (Check only on				
of V	ys dis	2	1 ☐ Yes 2X No		ent 2 ER/Outp		Othe Othe	er: 4 ☐ Nu		ome 5 Reside			y)	
n O		on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry Year) 28b. Tir Inj		8c. Injury Work			28d. Describe ho	ow injury o	ccurred		
Sio	Attending ir death. actor: Aftei by the fune	icat	2 Accident investigat 3 Suicide 6 Could not	be 290 Blace of Ini	uni. At homo fore	M street factor		Yes 2□	No	28f. Location (St	reet and N	lumber or Pure	I Route A	lumbor
Division	F 6 F C	Certification;	4 Homicide determine	building, et	ury - At home, farn c. <i>(Specify)</i>	n, street, ractory	, onice			City or Town		variiber or ribra	7 710010 71	idiliber,
_	Hospital	S S	29a. Certifier 14 Certifying	Physician: To the best	of my knowledge.	death occurred	at the tim	ne, date an	nd place,	and due to the ca	ause(s) an	d manner as st	ated.	
	e Hos e Fur letely	edical	(Check only 2 Medical Ex	aminer: On the basis of and manner st	f examination and/	or investigation	, in my op	pinion, dea	th occur	red at the time, d	ate and pla	ace, and due to	the caus	e(s)
	To the Hospital c	Me	29b. Signature and title of certifier	_		290	. License	e number		2	9d. Date s	igned (Month,	Day, Yea	r)
}	Y		111	M. T	<i>)</i> ,		D004	44635			Nov	vember	23,	2004
	10		30. Name and address of person wh	no completed cause of o	leath (Item 23a) (T	ype, Print)								
	(		John Harrison		nan Driv	e Balt	imor	ce, Ma	ary1	and 2120	7			
	Sta Registr		31. Date filed (Month, Day, Year) NOV 3 0 2004	32. Registr	ar's Signature	Spork	2							

			·	1 - For State Registrar	State of M		nd / Depa		lealth an	d Mental H	ygiene ()	4 37684
		Physici /Medic		Decedent's Name (First, Middle, La  Leslie Regina						2. Date of I	Day	Year 8:20 PM
		Examin Funeral Director		4a. Facility Name (If not institution, git  5. Social Security Number  6. 212-44-7274	re street and number)	SP1	last birthday) Yrs.	4b. City, Town, or Roy S	If Under 24	e	4c. County Bod / Birth Day, Year) 8, 1944	
		Maryland -f show fied at	tor	Usual Residence of Decedent  10a. State 10b. County  Md. Baltin	more		ty, Town or Loc Middle I					10d. Inside City Limits 1 ☐ Yes 2 X No
		3e or 28a	il Director	10e. Street and Number 9807 Tailspin La	ane Apt. G	1		10f. Zip Code	1220		10g. Citizen of W	/hat Country?
(	936	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-1 show other traumatic event, Ite Medical Exam is criment be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Nidowed 4 Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 1 1 Yes, Give Year or Dates:	Ever in U		as Decedent of H Yes, specify Cuba	ispanic Origin in, Mexican, P Specify:	? (Specify Yes or I uerto Rican, etc.)	No- 14. Race Black	e - American Indian, k, White, etc. : White
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N	, Mary	1 and 2 show Health and N em 27 is ma		19a. Informant's Name/Relationship  Calvin Kerner	(Type, Print) husband		19b. Mailing 9807			r Rural Route Num PApt. G	ber, City or Town, S Middle F	
651	Baltimore	permit. Pages 1 a Department of He Important: If iten any injury or oth- once.		20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special Contents)		(	Place of Disposicemetery, cremitary View	tion (Name of atory or other place Cremator	Y No	ov. 27 2004	20c. Location - 6	City or Town, State 1010
7	Balt	permit. Pages Department of Important: If ii any injury or once.		21. Signature of Funeral Service Lice	_ onvel	Oy.	ζ <sup>2</sup> ρ	Name and Address INELLY F 10 Solle	uneral rs Poir	Home Of it Rd. 21	Dundalk 222	
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	8760,	e be executed sician and e burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intifated events resulting in death) Last	b. Due to (or as  c. Due to (or as  d.	a conseq	uence of).	oscier	otic	CAL	)	
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	Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	200	Death (Check only		
	ion of	nding Phys tth. r: After this e funeral di	ation: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju		ER/Outpatient 28b. Time of Injury	28c. Injun	4 🔲 Nursir		sidence 6 Othe how injury occurre	
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		he Hospit n 24 hours he Funere pletely fille	edical (	29a. Certifier (Check only one)  1/2 Certifying P 2 Medical Exa	hysicien: To the best miner: On the basis o and manner st	f examina	owledge, death ation and/or inve	occurred at the time stigation, in my op	ne, date and propinion, death o	ace, and due to the	e cause(s) and man e, date and place, a	oner as stated. nd due to the cause(s)
		To the within Comp	¥	29b. Signature and title of certifier	vBn	2	un	29c. License		/		(Month, Dey, Year)
A		Sta	to	30. Name and address of person who by the first seek of person who be a filed (Month, Day, Year)	completed cause of cause of cause	S FC	ankli	n Solus	arel	Drive!	Baltim	12004 ore MD 21237
		Registr		NOV 3 0 2004	Sente	ر م	B A	south				

DHMH 17 Rev 1/2001

			For State Registrar	S	tate of	Marylan		artmen rtificat			and M	lental Hy	giene <sub>Reg.</sub> 2. (	04	37685
	Physici	an	1. Decedent's Name (First, Midd		77	1						2. Date of De Month	Day	Year	3. Time of Death  320 P M
	/Medic		Alfred C 4a. Facility Name (If not institutio					4b. City,	Town, or	Location of	of Death	NOVEM		Ounty of Death	320"
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	Funeral		5. Social Security Number	6. Sex 1 <b>½</b> M		Age (In yrs. 79	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	th ly, Year)	Cou	
	Director		217-12-3408 Usual Residence of Decedent			19						Feb. 16	,1925	Mary.	Land
1/27/14 death with the Maryland	show	_	10a. State 10b. County			10c. Cit	ty, Town or Lo							1	10d. Inside City Limits 1 ☐ Yes 2X No
The M	28a-f	Funeral Director	Maryland Balt  10e. Street and Number	imore			Arbu	tus 10f. Zip	Code				10g Citize	en of What Cour	
N. C.	3a or	i Di	1010 Circle	Drive					2122	7				U.S.A	•
rdeat	ams 2	ıner	11. Marital Status	12.	Was Deced	ent Ever in U	.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	- 14	Race - Americ	
36 rs afte	r, or it	by FL	1 ☐ Never Married 2 🖾 Mar 3 ☐ Widowed 4 ☐ Divorced		1 🔀 Yes 2 If Yes, Give Year or Dat	1/1/1/	II	1 🗆 Yes	2 <mark>₩</mark> No	Specify:			S	pecify: Whi	ite
2 hou	atura ical E	ted t	15. Deceder	nt's Education	on		16a. Dece	dent's Usua kind of wo	I Occupa	ation	t of work	ina	16b. Kind	of Business/In	dustry
Ithin 7	han "n	Completed	(Specify only higher Elementary/Secondary (0-12)		College (1-4	lor 5+)	life.	DO NOT us	se retired	)	t of work	ing			
filed v	al Hygiene. I other than "r vant, the Med	Co	12 17. Father's Name (First, Middle,	Last)			Ma	ainte	nanc		er's Name	e (First, Middle		ephone ( umame)	Company
an pr	fental rked c tic ave	To Be	Alfred Henry	Kerbe	e					F1	oren	ce Bost	on		
Maryland 21215-0036	and N Is ma		19a. Informant's Name/Relations											Town, State, Zip	-
<b>e, N</b>	Department of Health and Mental Hygiene. Important, or itams 23a or 28a-1 show Important: If Item 27 is marked other than "natural", or itams 23a or 28a-1 show any injury or othar traumatic avant, the Medical Examiner must be notified at once.		Shirley L. Ke	rbe	(Wife)	20b. F	Place of Dispo	sition (Nan	ne of			tus, Ma	-	nd 21227 ation - City or To	
mor	ent of nt: If it ry or o		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		oval from St	ate Me	emetery cie adowric morial	matory or o	ther plac	θ)	12-1	-2004		ldge, Ma	
Baltimore, permit. Pages 1 ar	Departm Importar any injur once.		21. Signature - Apparal Service	-		TITO	W <sup>2</sup>	2. Name an	d Addres				onevi	ille, Ir	iryranu oc
<b>a</b>	25 2 3	Ш	E TO	_		M0129	0 10	030 E	imon	dson	Ave.	Catons	ville	Mary	Land 21228
100			23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final	r complicationly one c	ons that cat ause on eac	ch line.			4			1	A		Approximate Interval Between Onset and Death
	nysician Medical		disease or condition resulting in death)	a	Due to (o	r as a conseq	plence of):	5056	VIA		U	i ci des	d		
E	xaminer		Sequentially list conditions.	b											
pel	ısit	Examiner	Sequentially list conditions, if any, leading to immediate cause Enail Uncertainty Cause (Disease or injury	₹	Due to (or	r as a conseq	quence of):							4	
<b>)</b> , ехеси	n and ial-trar	Exan	that initiated events resulting in death) Last	c	Due to (or	r as a consec	quence of):								
. Box 68760, death certificate be executed	physician and the burial-transit	cal		d											
x 68	attending ph I for use as t	Physician/Med	IF FEMALE:	220	If yes outco	ome of pregna	ancv						-		
Box leath cert	attend for us	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		1 Live bir	th 2 Feta	al death 3	⊒Ectopic pr ⊒ Other (sp					23	d. Date of delive Month	ery Day Year
P.O.	by the a	hysi	9 Unknown		9□Unknov	vn									
	signed d be det	by	Part II. Other significant condit	ons contrib	uting to dea	ith but not res	sulting in the u	inderlying c	ause give	en in Part I.		23e. Did t			he cause of death?
Records,		ompleted										24a. Was			psy findings available
Rec The law	_ <u>_</u>	ошо										auto		prior to co death? 1 \( \text{Yes}	mpletion of cause of 2 No
	certificate irector, pag	BeC	25. Was case referred to medica examiner?								of Deati	(Check only o			
of Vita Physician:	this cr	၉	1 ☐ Yes 2 ☑ No 27. Manper of Death	Hosp	oital: 1 □ Inj 28a. Date of		ER/Outpatie		- 4	4 🗀 190		me 5 ☐ Resi		Other (Specif	in hospice
	h. After fune	tion;	1 🗖 Natural 5 🗍 Pendi		(Month	Day Year)	Injury	M	8c. Injury Work 1 🔲	k? Yes 2□		200. 0000100	now injury	00001100	
	after death. Diractor; A I in by the fu	Certificatio	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern		28e. Place o	of Injury - At h	ome, farm, st	reet, factory	, office			28f. Location ( City or To		Number or Rura	al Route Number,
Di pital or	urs aft sral Di	Cer	00-0-19-	Ph				h			4 -1				A-Ad
A Hospital		edical				is of examina								nd manner as s lace, and due to	
To tha	withir To th comp	Me	29b. Signature and title of certific	er 🔿				290	. License	number				signed (Month,	
1			P YM II	~	)			]	DHO	185L	l		ì	11241	woy
	ρ		30. Name and address of person	who comb	leted cause	of death (Iter	m 23a) (Type,	Print)	Rall	Limos	C+	md.	212	65	
***	Sta		31. Date filed (Month, Day, Year			gistrar's Signa	ature /		Ms			11.00	JC 100	~~	
75	Regist	rar	NOW 2 O	2004	5	all product	19	poo	des						

		•	For State Registrar	State of	of Marylar	nd / Depa <i>Cei</i>	irtment of <i>tificate c</i>	Health and If Death	d Mental Hy	/gienze 0 0	4 37686
1	Physicia /Medic		1. Decedent's Name (First, Midd.  Edward Anthony						2. Date of D Month	Day	Year J: 19 P M
	Examin		4a. Facility Name (If not institution 3029 East Ave	n, give street and nu	m <i>ber)</i>		4b. City, Town	n, or Location of De Baltimo:		4c. County o	
	Funeral Director		5. Social Security Number 214-22-9109	6. Sex 1 M 2 ☐ F	7. Age (In yrs.	last birthday) 76 Yrs.	If Under 1 Ye Months Da	ar If Under 24 F		irth lay, Year)	Birthplace (State or Foreign Country)     OH
	inyland show	_	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	ith the Ma or 28a-f s	Director	MD Balti 10e. Street and Number	more	Ba	ltimore	10f. Zip Cod	9		10g. Citizen of W	1 Yes 2 No
-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Madical Examination reliting a	by Funeral	3029 East Aver 11. Marital Status 1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced	12. Was Dec Armed F ried 1 7 Yes	edent Ever in U orces? 2 No ive Dates: W. W		21234  Was Decedent of Yes, specify Co	To Specify:	(Specify Yes or Nerto Rican, etc.)	Specify:	- American Indian, c, White, etc.
9200-91212	e filed within 72 I Hygiene. other than "na ent, Ine Medic	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed,	1-4or 5+)	(Give	kind of work do OO NOT use re	ne during most of t	working	Engineer	,
⊆	ed ala	To Be C	17. Father's Name (First, Middle, Edward Joseph					18. Mother's N	Name <i>(First, Middle</i> Lutian	e, Maiden Sumame	9)
	and 2 shi ealth and n 27 is m		19a. Informant's Name/Relation: Debbie Amrhine		lan.	3029	East Av	enue, Ba	ltimore,	ber, City or Town, S	
altımore,	Pages 1 ment of H tant: If iter jury or oth		20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation  4 □ Donation 5 □ Other (5)		State	laney		Memorial	Date Dec 3 2004	20c. Location - 0	City or Town, State
Ball	permit. Page Department of Important: If any injury or 2000e.		21. Signature of Funeral Service	lell_	M009	80	Cremation 3717 Great	en Pastu	res Driv	ternative e Baltin	nore MD
	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	aLV	each line.	HNCET		rying, such as card	diac or respiratory a	arrest,	Approximate Interval Between Onset and Death
98760,	ficate be executed physician and is the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause, Usads of him y that initiated events resulting in death) Last	C	(or as a consec						
P.O. Box 6	ath certi attending for use a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	1 ☐ Live	atcome of pregn birth 2 ☐ Feta nant at time of c	aldeath 3□	Ectopic pregna Other (specify			23d. Date Mon	of delivery th Day Year
	w requires that the de been signed by the should be detached		Part II. Dther significant condit	ons contributing to	death but not res	sulting in the u	nderlying cause	given in Part I.			bute to the cause of death? 3 ☐ Probably 4 ☑Unknown
l Records,		Completed							24a. Wa: auto perf 1 □ Yes	opsy proformed? de	/ere autopsy findings available rior to completion of cause of eath?  ☐ Yes 2☐ No
of Vita	Physician: The law this certificate has b al director, page 2 s	To Be	25. Was case referred to medical examiner? 1 \( \sum \text{Yes} \) 2 \( \text{No} \) No	Hospital: 1		ER/Outpatier	1 3 DON	Other: 4 Nursin		sidence 6 Othe	
Division of Vital	ding I	ertification;	3 Suicide 6 Could	igation not be	e of Injury e of Injury - At h	28b. Time of Injury	М .	njury at Work? Yes 2 No	28f. Location		or or Rural Route Number,
<u>N</u>	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	0	29a. Certifier 1 💆 Certifyi	ng Physician: To th	ling, etc. (Speci	fy)				own, State)  cause(s) and mar	nner as stated.
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical	(Check only one)  2 Medice  29b. Signature and title of certifi	and ma	basis of examination of stated.	ation and/or in	29c. Lic	ense number		29d. Date signed	nd due to the cause(s)  (Month, Day, Year)
'n	1/		30. Name and address of person		F 7	m 23a) (Type,	Print)	04762		11/27/	
:3	Sta		RICHARD O'W 31. Date filed (Month, Day, Year NOV 3	) 32.	Registrar's Sign		er or	LIVE, SI	rite 31	, Tows	on, Mp. 21204

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 37687 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician 4:12a** <sup>™</sup> M. Virginia Kahn NOV 2004 /Medical 28 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Sykesville

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Month, Day, Year)

Mar. 24, 1915 Fairhaven Retirement Community
Social Security Number 6. Sex 7. Age (In yrs. last birthday) Carroll 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F 220-07-9544 89 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-f show other traumetic event. The Madical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue 21784 USA Funerai 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural, or Item any Injury or other traumetic event, the Madical Examinations. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: White Specify: Completed by 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Administrative Assistant Dietary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Henry M. Witmyer Ruth Harrison ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Slade Avenue Apt.209 Baltimore, MD 21208 Linda K. Zuskin, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) 11/29/04 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Services icensee 2 Name and Address of Facility Cremation Society Of Maryland 299 Frederick Road Baltimore, Inc. Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 3nc RA Month disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner as the burial-transit the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 ☐ Yes 2 ☐ No 2 **X**No l or Attending Physiclan: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 V Other (Specify) 1 Yes 2XNo 2 3□ DOA this Living To the Funaral Director: After the completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel within 24 hours a To the Funaral I 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cal 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) November 29,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 295 Appel, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signaturé State Registrar NOV 3 0 2004 Sporks!

DHMH 17 Rev 1/2001

			For State Registrer	State of Ma	aryland		artment of tificate of		nd Mental H	ygiene Reg. No.	004	37688
	Phoneist		1. Decedent's Name (First, Middle, L						2. Date of I		Year	3. Time of Death
	Physici /Medic		Ande	r D. Killet	t				Kovem	ber 2	6 2a	4 0334 AM
	Examin	er	4a. Facility Name (If not institution, g Union Memorial				•	n, or Location of altimore		4c. C	N/A	ath
	Funeral Director		5. Social Security Number 6. 215–64–9664	Sex 7. Age	49 (In yrs. las	t birthday) Yrs.	If Under 1 Ye Months Da		Min. 8. Date of to (Month, SEP 1,	Birth Day Year) 1955	- C	rthplace (State or Foreign country) rth Carolina
	pu »		Usual Residence of Decedent  10a. State 10b. County		10c. City, 1	Cours or Lo	nation					10d. Inside City Limits
	faryla February February	or			Too. Oity, I	OWIT OF LO	cation	Baltimo	<b>*</b> 0			14 Yes 2 □ No
	28e-	Director	Maryland N/ 10e. Street and Number	A			10f. Zip Cod		re	10g. Citize	en of What C	
	h with	al Di	326 East 21st	Street			21	218		J	JSA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "naturel", or Items 23a or 28e-f ehow empt injury or other traumatic event. The Medical Examiner must be notified at an once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Decedent f Yes, specify C		n? (Specify Yes or Puerto Rican, etc.)		1. Race - Am Black, Wh Specify: B1.	
2	72 ho natur	eted	15. Decedent's (Specify only highest g		1	(Give	lent's Usual Ockind of work do	ne during most o	of working	16b. Kind	d of Business	s/Industry
2121	d within giene. ar then	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Labor	oo not use re er	tirea)		Wa	arehou	se
Maryland 21215-0036	d be file intal Hy ad othe	Be	17. Father's Name (First, Middle, Last Henry Kill	*					s Name <i>(First, Midd</i> .ttie McKr		umame)	
Ž	should nd Me : mark matic	2	19a. Informant's Name/Relationship			19b. Mailin	g Address (Str		or Rural Route Nun		Town, State,	Zip Code)
Ĭ,	and 2 raith a 27 is er trau		Frances M. Kille	tt/wife		326 E	East 21s	st Stree	t Balti	more,	MD 21	218
altimore,	ages 1 ant of He it: If item		20a. Method of Disposition 1 □ Burial 2 XCremation 3 14 □ Donation 5 □ Other (Spec		cem	eterv, cren	sition (Name of natory or other ematory	olace) Inc. 11	Date /29/04	20c. Loca		imore, MD
Baltir	permit. F Departme Importer eny injur		21. Signature of Funeral Service Lightonian Thomas Gre	ensee			Crema C		ety of Ma	ryland timore		
			23a. Part1. Enter the disease, or co shock, or heart failure. List only	mplications that caused	the death.	Do not ente					:, rid	Approximate Interval Between
	Pnysician	i i	Immediate Cause (Final disease or condition	Ity	DON	a						Onset and Death
	/Medical Examiner		resulting in death)	Due to kra	consequer	nce of):						
		-	Sequentially list conditions, if any, leading to immediate	b. Due to ( r as a	a consequer	nce of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the day, if Cause (Disease or injury that initiated events	C								
8760,	ficate be executed physician and is the burial-transit	al Exa	resulting in death) Last	Due to (or as a	a consequer	nce of):						
687	fficate g phys	edical	-5	d						Pane		
. Box	The law requires that the death certific tite has been signed by the attending p page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of 1 Live birth 24 Pregnant at	2 Fetal de	ath 3	Ectopic pregna Other (specify			23	d. Date of de Month	Day Year
о. О	res that the de signed by the a i be detached f	Phys	9 Unknown	9□ Unknown	A 4 181-	!	4.4.5	- In Cont	an Di	1.1.1		
rds,	w requires that been signed should be det	by	Part II. Other significant conditions	contributing to death bu	it not resulti	ng in the ur	ideriying cause	given in Paπ I.		Yes 2		robably 4 Dunknown
Records,	e law requ has been je 2 shoul	Completed							24a. Wa	as an topsy formed?		utopsy findings available completion of cause of
Vital			25. Was case referred to medical					00 Blass a	1 ☐ Yes	2 No	1 🗆 Ye	
$\geq$	ysicia is cert directe	o Be	exammer?	Hospital: 1 ☐ Inpatier	nt 2□ER	VOutpatient	BEDOA	Othor	ing Home 5 Re		Other (Sp.	ecify)
n 0	Attending Physician: r death. actor: After this certification the funeral director.	on: T	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day		Bb. Time of Injury	28c. l	njury at Nork?		e how injury o		
Sio	Attendio death. ctor: A y the fu	catle	2 Accident investigati	he				☐Yes 2☐No		(5)		
Division of	or Direction	Certification:	4 Homicide determine		ry - At home :. (Specify)	e, farm, stre	eet, factory, offi	ce	281. Location City or 7	(Street and I own, State)	Number or H	tural Route Number,
	To the Hospital or Attan within 24 hours after deat To the Funerel Diractor: completely filled in by the	Medical C	29a. Certifier 1 Certifying F (Check only one)	Physician: To the best of eminer: On the basis of	examination	edge, death n and/or inv	occurred at the	e time, date and ny opinion, death	place, and due to the	e cause(s) ar e, date and p	nd manner a lace, and du	s stated. e to the cause(s)
	o the o the omple	Med	29b. Signature analytitle of certifier	and manner stat	. Deg.		29c. Lic	ense number		29d. Date :	signed (Mon	th, Day, Year)
ı	PSFO		· CONC	1)			D	00554	159	Make	where	29,200+
	10		30. Name and address of person wh	o completed cause of de	eath (Item 23	3a) (Type, i	Print)	110.00	, M, -	CC	111	0-1-1
	Sta	te	31. Date filed (Morth, Day, Year)	32. Registra	ar's Signatur	· VV	VI)	WIIG	4 Hem	Cria	110	spira)
	Registr		MOV 3 0	2004	never	10	pp	nes			•	

			1 - State Amend Item 23 Registrar	State of Mary a,pt.II,23	land/Depa ,228a-Cer	rtment of He er me G82 tificate of L	ealth and l Death	Mental Hy 05 tas	giene Reg 2004	37689
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De	eath Day Ye	3. Time of Death
	/Medic		Rachel				scher	Nove	nber 27 2	00-1 0752 AM
	Examin	ner .	4a. Facility Name (If not institution, give s			4b. City, Town, or I		1	4c. County of E	
			Johns Hopkins 6. Sex		yrs. last birthday)	Balti-	If Under 24 Hrs.	9 Date of Bi	Bultin	
ł	Funeral Director			M 2X F	29 Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, Di 2/21/	ay, Year) 1975	Birthplace (State or Foreign Country)  MD
	land ow		10a. State 10b. County	10	c. City, Town or Loc	ation				10d. Inside City Limits
	Manylan -1 show   - u =1	tor	MD Baltimore		Rosedale					1 ☐ Yes 2X No
	r 28e	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	h witi	al D	7923 31st. St.			21237			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-1 show any follury or other traumatic event. It a Medical Ever's at most be neithed at once.	by Funeral Director	11. Marital Status 1  12 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If	Vas Decedent of His Yes, specify Cuban ☐ Yes 2 XNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		American Indian, Vhite, etc. Vhite
21215-0036	within 72 hou ene. then "natura ive Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give I	ent's Usual Occupa kind of work done di OO NOT use retired)	uring most of won	king	16b. Kind of Busine	ess/Industry
	filed wil Hygien ther th	Con	3	0	Dis	abled			Disabl	.ed
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)						, Maiden Sumame)	
yla	Men J Men narke	2	Hert Kirtscher Jr.				Joan V.			
, Maryland	alth and 2 sh		19a. Informant's Name/Relationship (Typ. Joan V. Kirtscher/		19b. Mailin	g Address <i>(Street al</i> 31st St		dale MD	er, City or Town, Star 21237	te, Zip Code)
Baltimore,	Pages 1 a lent of He nt: If item ry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	20b. Place of Dispos cemetery, crem Dulaney V	atory or other place	a)	Date 29/04	20c. Location - City  Timonium	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service License		22.	Name and Address	s of Facility C	vach/Ros	sedale Fun re MD 2123	eral Home
68760,	/Medical Examiner but side personner but side private side side private side side private side side side side side side side sid	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	•		ONED BY WEDICE	L EXAMINER	5 days
P.O. Box 68	requires that the death certific: een signed by the attending pl tould be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	CE Ectopic pregnancy Other (specify)	RIFICHEN		23d. Date of Month	delivery Day Year
	s tha	by P	Part II. Dther significant conditions con				n in Part I.		,	e to the cause of death?
rd	w require been sig should b	ed	anoxic bich	1)414 , a	diabete.	5		1 🗆	Yes 2127No 3□	Probably 4 Dunknown
Records,	The law ate has by page 2 sh	Completed						24a. Was auto perfe 1 \sum Yes		
of Vital	icien: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	one)	
Ž	Physicien: r this certific ral director,	2	1 XYes ZINO	ospital: 1 Inpatient	2 ER/Outpatient		# 🗀 Indising A	ome 5 ☐ Resi	idence 6 Other (S	Specify)
Division c	ding Afte fune	Certification:	27. Manner of Death    Tantural   5   Pending	28a. Date of Injury (Month, Day Ye 1983 28e. Place of Injury building, etc. (S	- At home, farm, stre		at ? /es 2. <b>X</b> No <b>IIII k</b>	Subject	how injury occurred  t nearly d  Street and Number of wn, State)	rowned r Rural Route Number, un
	To the Hospital or Attent within 24 hours after deall To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Continuing Trys (Check only one) 2 Medical Examin	eian: To the bast of m er: On the basis of exa and manner stated	amination and/or inv	occurred at the time estigation, in my opi	e, date and place, inion, death occur	, and due to the rred at the time,	date and place, and	r as stated. due to the cause(s)
}	To the within 2 To the complet	Σ	29b. Signature and title of certifier  Whise Mon	the no		29c. License	number		29d. Date signed (M	onth, Day, Year) - 24, 2004
	3	1	30. Name and address of person who con  Nisa Mary Hy	noleted cause of death	(Item 23a) (Type, I	Print)				1 21287
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature		, 0-117		7,000	,
	ricgisti	Ţ	NOV 3 0 2004	A POLICE	Kr GOS					

Amend item tare of Markand / Department of Health and Mental Hygiens 37690 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Z 29 PM ELIAS KOKOS November 20 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Centry Baltimore N/AIf Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) CZIGHOSIOVAKIA JULY 25, 1932 7 ECKOSLOVAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral ™** M 2□ F 051-54-9153 72 Director Usual Residence of Decedent with the Maryland r than \*natural', or items 23a or 28a-f ehow the Madical Examinar must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Directo N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 603 S. ANN STREET APT. U.S.A. 515 21231 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 PRIEST RELIGIOUS other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ont of Health and Mental I t: If item 27 is marked of y or other traumatic ever Mental 8 JAN KOKOS MARIA **GELOVA** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 2 3 1 19a, Informant's Name/Relationship (Type, Print) MARIA KOKOS/ WIFE 603 S. ANN STREET, APT. 515, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of important: If any injury or once. BAYVIEW CREMATORY 11/26/04 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 15-5 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Emboli DAY5 /Medical Due to (or as a cons - lence of): **Examiner** Coronary Artery Disease VEARS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): I HECOrds, P.O. Box 68760, <. The law requires that the death certificate be executed. Diabets Mellitus VEARS Due to (or as a consequence of): P.O. Box 68760, physician Horcholestorolomia Physician/Medical YEARS the attending for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ DEPENDENC ETHANOL 1 Yes 2 No 3 Probably 4 Winknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irrector, page 2 s autopsy performed? Yes 20 No 1 Yes 1 Yes or Attending Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes this After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide To the Hospitat Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D59783 November 20 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Param Ded his MD Johnstopkins BoyMan/Medical Center #AO Eastern Avenue Bathmere Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registramend ITEM #9 PER FH G838 12/08/7/69/16 of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** DARRELL YOA M THEODORE KUHN SR. Vovember 2004 /Medical 4a. Facility Name (If not institution, give street and number) County of Death Bity, Town, or bocation of Death Examiner 65pch Oten Worn 17 Hrunde If Under 1 Year | If Under 24 If 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace Country) **Funeral** (State or Foreign Days Hours 1X M 2□ F 234-30-8371 Yrs. 81 Director OHIO Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Iteme 23e or 28e-f show treumatic event, the Medical Erant for must be trailled at MD Anne Arundel 1 ☐ Yes 2 X No Pasadena Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8352 Capel Drive 21122 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seagrams 12 Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be and Mental I Grant Livingston Kuhn Twigg Treva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an item 27 is 8352 Capel Dr., Pasadena, MD 21122 Mrs. Kitty Kuhn / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent; If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 12/1/2004 Brooklyn,MD \* 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. I Second Ave SW Glen Burnie MD 21061 21. Signature of Funeral Service Duenses M01364 1 Second Ave SW 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset/and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to-(or as a consequence of) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit a certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical the t as puipi Box ( use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery atten 3 Ectopic pregnancy ίο in the past 12 mon Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached for P.0. 9 Unknown 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autoosy gerforme 1 Yes 2 Do 1 Yes 2 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient P 1 Tyes 2 ER/Outpatient 3 DOA this 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a 1 Stitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and 4t 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

Year)

NOV 3 0 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygienen 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Tayeer Day Month 3 2c04 ZACHEL **Physician** KLINEFELTER Vembe 100 A.M /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Randallstown Northwest Hospital Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Africa Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🖾 F 97 Yrs Director July 14,1907 MD 220-18-4723 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Importent: if item 27 is marked other than "natural", or itams 23e or 28e-f ahow any injury or other treumatic event, ite Maclical Exercites from the notified at any injury or other treumatic event, ite Maclical Exercites from the notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director Carrol1 Finksburg 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 2525 Baltimore Blvd. #12 21048 Funeral USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Bendix 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be David Allan 2 Julia DeVese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Klinefelter 47 Railroad Ave., Glyndon, MD 21071 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 11/24/04 \* 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 -cms nu Approximate Interval Between Onset and Death art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. rediate Cause (Final ATRIAL (-1BOZICLA DOM Physician disease or condition resulting in death) À /Medical Due to (or as a consequence of): Examiner ADOD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ONAM that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician THEORD Physician/Medical as the IF FEMALE nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ö in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No detached 9 Unknown 9 Unknown á 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed þ pe MSUPPICENC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? VASCUMAN DISGAIG has autopsy performed? certificate 2 No 1 Yes 2 No 1 TYes Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funerel Director: After t 5 Pending investigation 1 Natural М 1 Tyes 2 No 2 Accident 6 Could not be determined 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Nem 23a) (Type, Print) majucely 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 2004 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiege 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 25 KURMANOL Month Da NOVEMAER GENNADIT **Physician** Year 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Logation of Death Examiner MANDAUSTINN NORTHWEST HOSPITAL BALTI 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 5, 1961 5. Social Security Number 6 Sax 9. Birthplace (State or Foreign **Funeral** Days 1⊠M 2□F 220-39-9913 Yrs. Director 43 Russia Usual Residence of Decedent tha Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits item 27 ie markad othar then "naturel", or Items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1√Yes 2 No Director Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6803 Cherakee Dr. USA 21209 death 1 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other then "naturel", or Iter 1 ☐ Never Married 217 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Computer programmer goverment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michail Kurmanov unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parmit. Pages 1 and 2 sh Department of Health and Important: If item 27 le rr any injury or other traum QDCs. Tanya Kurmanova – wife 6803 Cherakee Dr. Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State 11/27/04 \* 4 ☐ Donation 5 ☐ Other (Specify) All Saints Cem. Reisterstown, MD Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Rd Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final IRRHOSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner cartificate be exacuted the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical use as IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 Yes 2 19-No 1 Yes 2 No 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2/☐ No Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NOVEMBER 25 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Pripa) MO NHC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1- State of Maryland		artment of H rtificate of			200 L	37694
	Physici	an	Decedent's Name (First, Middle, Last)     Anna Marie	Kotl	arz		2. Date of Dea Month	Day Ye	Q • 13 7 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  12210 Lanham Severn Road		4b. City, Town, o	or Location of D	Novembe Death	4c. County of D	)4
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. I. 212-16-8152 1 □ M 212 F 89	ast birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birtl (Month, Day Oct. 9	v, Year)	Birthplace (State or Foreign Country) [aryland
	or death with the Maryland tams 23a or 28a-f show ar must be notified at	ctor	Usual Residence of Decedent           10a. State         10b. County         10c. City           Maryland         Baltimore	r, Town or Lo		dgemere			10d. Inside City Limits 1 ☐ Yes 2XXII0
	with the	Director	10e. Street and Number 8100 Penwood Avenue		10f. Zip Code	21219		10g. Citizen of Wha United S	
36	afte or 1	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  1 Ves 3 No If Yes, Give Year or Dates:		Was Decedent of it If Yes, specify Cub 1 ☐ Yes 2020No	Hispanic Origin pan, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - A Black, V	American Indian, White, etc. White
21215-0036	s 1 and 2 should be filed within 72 hours if Health and Mental Hygiene. item 27 Is marked other than "natural; other traumatic event, the Medical Eve	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire Housewi	during most of d)	working	16b. Kind of Busine	ess/industry Home
and 2	12 should be filed within h and Mental Hygiene. 7 Is marked other than "traumatic event, the Men	Be	9 Years  17. Father's Name (First, Middle, Last)  Logan O. Spivey		Housewi		Name (First, Middle,		
Maryland	should and Me is mark	°L P	19a. Informant's Name/Relationship (Type, Print)			t and Number o	or Rural Route Numbe		
	Health Health tem 27 I		Brenda Dolinar / Daughter  20a. Method of Disposition 20b. P	lace of Dispo	Penwood  osition (Name of matory or other pla		Date Date	e, Maryla: 20c. Location - City	
Baltimore,	Page nent o nnt: If ury or		1½ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Oa	k Lawr	Cemeter	y 11/2	27/2994	Baltimo	re, Maryland
Bal	permit. Departn Importe any inju		21. Signature of Funeral Service Licensee	r	922 Wise	Funera Ave.		Maryland	21222
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as also need to be condition)	Do not en	teri de mode of dy	ding, such as cal	rdiac or respiratory ar	rest,	Approximate Interval Between Onset and Death 3 years
8760,	icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a confequence of the confequence	, •					,
O. Box 68	ath certif ittending or use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	□Ectopic pregnanc □ Other (specify) _	ey		23d. Date of Month	delivery Day Year
rds, P.	quires that the de n signed by the a uld be detached f		Part II. Other significant conditions contributing to death but not result	ulting in the u	inderlying cause gi	ven in Part I.	23e. Did to	_/	te to the cause of death?  Probably 4 Dunknown
Records,	The law requir ate has been si page 2 should	Completed						rmed? prior deat	e autopsy findings available to completion of cause of h? Yes 2 \( \subseteq \text{No} \)
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Ot	har	Death (Check only o		Daughters SpecifyResidence
of	ding Phys	on: To	27. Many of Death 1 Natural 5 Pending (Month, Day Year)	28b. Time of	f 28c. Inju	iry at ork?	28d. Describe h	now injury occurred	Specify (CD 1 = CC)
Division	or Attano ifter death Diractor: in by the	Certification:	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At he building, etc. (Specify	ome, farm, st		]Yes 2∏No		Street and Number o vn, State)	r Rural Route Number,
_	To the Hospital within 24 hours a To the Funeral Completely filled	Medical Ce	29a. Certifier (Check only one)  Certifying Physician: To the best of my kno (Check only one)  Certifying Physician: To the best of my kno and manner stated.						
	To the He within 24 To tha Fu completei	Mec	29b. Signature and title of certifier		29c. Licen	se number 14793	,	29d. Date signed (M	lonth, Day, Year)
	5		30. Name and address of Assis ho completed cause of death (Item	4 /	Print)	Acr	Balto	mD o	71222
	Sta Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signa	ture	doo	Ker			

			1 - For State Registrar	State of Marylar		artment of H				06	37695
			Decedent's Name (First, Middle, La	st)		Timoato or E		2. Date of De	Reg. No.	O = F	3. Time of Death
	Physici	an	Loretta Anne Lis:	,				Month Novembe	Dav	Year	
	/Medic Examin		4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, or	Location of De		4c. Count	ty of Death	10:10 P <sup>M</sup>
			Charlestown Care			Catonsv		(	Balti		
	Funeral Director		212-36-3602	Sex 7. Age (In yrs. 1 ☐ M 2 🖫 F 92	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		th y, Year) 14,1912	9. Birtho Cour Mary	otace (State or Foreign otry) 1and
	and *		Usual Residence of Decedent  10a. State 10b. County	10c C	ity, Town or Lo	ocation				1	0d. Inside City Limits
	faryli sho	ō			•						1 ☐ Yes 21 No
	the N 286-1	ect	Maryland Baltimon  10e. Street and Number	re [Cat	onsvil	I. e 10f. Zip Code			10g. Citizen of	What Cour	
	with Sa or	ā	715 Maiden Choice	. Lane		21228			USA	What oou	My.
	Jeath	era	11. Marital Status	12. Was Decedent Ever in L		Was Decedent of His	spanic Origin?	(Specify Yes or No		ce - Americ	an Indian.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mentel Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumetic event, If a Medical Examinar must be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		tf Yes, specify Cubar	Specify:	èrto Rican, etc.)	Bla	ack, White, by: Whit	etc.
ਨ੍ਹ	2 ho	ted	15. Decedent's E			dent's Usual Occupa			16b. Kind of Business/Industry		
21,5	thin 7	pie	(Specify only highest grant (0-12)	College (1-4or 5+)	life.	kind of work done do DO NOT use retired)	uring most of t	vorking			
7	ed wi	Con	8		Homen					Home	
Maryland	be fill d oth	Be	17. Father's Name (First, Middle, Last Frank Milanicz	)		18. Mother's Name (First, Middle, Maiden Sumame)  Agnes E. Pietrowiak					
풀	d Mer A Mer nerke	ပ္		T D.: 1	401 44 111						
Ma	d 2 sl th and the r		19a. Informant's Name/Relationship (	_		ng Address (Street a.					
ō,	1 an Heal tem 2		Charles W. Smith 20a. Method of Disposition	Son   20b. I	Place of Dispo	Maiden Cho		Date Caton	SVIIIe, 20c. Location		
<u></u>	ages ant of at: If if		1 StBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Theinoval irom State	cemetery, crer Stani	natory or other place slaus		/30/2004	Baltim		
Baltimore,	ermit. F Departme nporter iny injur		21. Signature of Funeral Service Lice		22	Name and Address	s of Facility				
_	40240		222 Part Enter the disease or com	unlications that caused the deep	/	36 Edmond	lson Av	<u>enue; Cat</u>	onsvill	e, MT	21228 Approximate
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.					rest,		Interval Between Onset and Death
ı	Pnysician /Medical		disease-or condition resulting in death)	a. Cerebral  Due to (or as a consec		ular	Acci	dent		-	
	Examiner			Due to (or as a consec	quence or);						
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	cuted	Examiner	Cause (Disease or injury that initiated events	c							
8760,	ficate be executed physician and sthe burial-transit	EX	resulting in death) Last	Due to (or as a consec	uence of):						
387	physicate the t	dical		_ d.							
×	certif Iding	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy				234 Da	ate of delive	ND.
Box	death e atter d for u	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		Ectopic pregnancy Other (specify)				onth	Day Year
o.	t the c by the ache	hys	9 Unknown	9□ Unknown							
S, F	engi engi p eq	ρ	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying cause giver	n in Part I.	1			e cause of death?
ord D	w requir been si should	ted						- 1LIY	es 2□No	3 ∐ Prob	ably 4 Donknown
Division of Vital Records, P.O.	The la	Completed							med?	prior to cor death?	psy findings available inpletion of cause of 2 No
ita	ilcien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					eath (Check only of			
<u>&gt;</u>	Physic this or al dire	P.	1 ☐ Yes 2 ☑ No	Contract of the Contract of th	ER/Outpatien			Home 5 ☐ Resid			)
ŭ	Attending Physicien: r death. ector: After this certific by the funeral director.	ion:	27. Manner of Death 1 ☑ Naturat 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of tnjury	Work	?	28d. Describe h	ow injury occur	red	
<u>S</u>	death death ctor: / the l	icat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	O O O O O O O O O O O O O O O O O O O	ome farm str		es 2 □No	28f. Location (S	treet and Numi	her or Rura	l Route Number
<u>&gt;</u>	Hospitel or Attens 14 hours after deatl Funerel Director: tely filled in by the	Certification:	4 ☐ Homicide determined	building, etc. (Specil	y)	eet, factory, office		City or Tow	n, State)	on or ribra.	rnoute wamber,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical (	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time restigation, in my opi	e, date and pla nion, death oc	ce, and due to the c curred at the time, c	ause(s) and ma date and place,	anner as st	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signe	d (Month, L	Day, Year)
	h		Deveen L	Bowlin , n	w	044	377		11/27	104	
	'h	15	30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print)	,	2 1	* 11	· - /	0.10 0.4
			Deneen Bow (in 31. Date filed (Month, Day, Year)	mD 711 N 32. Registrar's Signa	raides	1 Choice	Lar	e, Catoni	sville	mo	21228
	Sta Registr		NOV 3 0 2004	September 1	9 4	Print) n Choice					

State of Maryland / Department of Health and Mental Hygien 🔊 🛭 🗓 👢 37696 For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Robert S. Lazarewicz November 23 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10236 Fairway Drive Ellicott City Howard If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Y Apr 7, ] Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F Months New York 63 1941 Director 078 34 8151 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show id other then "natural", or Itams 23s or 28s-f showevent, the Medical Example strought be notified at 1 Tyes 2 XNo Directo Howard Ellicott City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10236 Fairway Drive 21042 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Yes 2 No 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1968-70 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: if item 27 is marked other then "n any injury or other treumatic event, its Mexico. College (1-4or 5+) Elementary/Secondary (0-12) 5+ Administrator County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stephen John Lazarewicz Elizabeth Alice Cyrulewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie S. Copeland/Wife 820 William Street #101 Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11-27-2004 Ellicott City, MD Good Shepherd Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee M01044 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Collins 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Upper Gastrointestinal Hemorrhag Immediate Cause (Final disease or condition resulting in death) **Physician** minutes /Medical Due to (or as a consequence of) **Examiner** Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner at or Attending Physician: The law requires that the death certificate be executed after death.

after death.

Director: After this certificate has been signed by the attending physicien and in by the funeral director, page 2 should be detached for use as the burial-transit and by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2X No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1**X** Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and itle of certifie Deput 29c. License number 29d. Date signed (Month, Day, Year) D31473 November 23, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cone Way Ellicott City MO 21042 Hemlock PATPYCE A. TOKE MD 31. Date filed (Month Day, Year) NOV 3 0 2004 22. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2001 37697 1 - For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 26 2004 Physician 5:50 AM Richard H. Lowe, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Catonsville Catonsville Commons | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept 21, 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral . 1932 Maryland Yrs. 72 212 32 9525 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a, State or 28a-f ahow inermust be notified at 1 ☐ Yes 2 ☑ No Director Ellicott City MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21043 United States 5008 Ilchester Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. β Specify: other traumatic event, the Medicul Ever White 3X Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: if item 27 is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) Manufacturer Press Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Marie Easton Richard H. Lowe, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21104 4116 Wards Chapel Road Marriottsville, MD Warren R. Lowe/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: if it any injury or c 1 XBurial 2 Cremation 3 Removal from State St. Mary's Cemetery 11/30/2004 Ellicott City, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ATH EROSCUEROTIC CARDIOVASCULINA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ DIABETES 1 Yes 2 No 3 Probably Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 25 No 1 Yes director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Sursing Home 5 Residence To 1 Yes 2 No 6 Other (Specify) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed Box 68760 P.O. Records,

Baltimore, Maryland 21215-0036

Division of Vital or Attanding Physician: Hospital

death. after death filled in by

within 2 the

WALVA CEPSAR 31. Date filed (Month, Day, Year) State

Medical

4 | Homicide

(Check only one)

29a, Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

NOV 3 0 2004

determined

29c. License number

STREET

BALTIMORE

29d. Date signed (Month, Day, Year) MOVEMBER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NORTH ENTAW

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Ernest Saul Lantz November 24, 2004 4c. County of Death 5:00 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Genesis Elder Care at Perr.Pkwy Parkville

| If Under 1 Year | If Under 24 Hrs. |
| Months | Days | Hours | Min. | Baltimore 6. Sex 1∕ 1⁄ 2 F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 232-05-6472 91 Director Feb 16,1913 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State r then "natural", or Itams 23a or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD. Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8309 Oakleigh Road 21234 Funeral <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Steel Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be ind Mental Rememberance Saul Lantz Ada Jones 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any injury or other traum QRCs. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8309 Oakleigh Rd., Parkville ce of Disposition (Name of 20c. Local <u>Mr. Ernest E. Lantz/Son</u> MD. 21234 Baltimore, 20b. Place of Disposition (Name of Chesapeake Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 11-26-2004Beltsville, MD. 21. Signature of Funeral Sprvice Licensee 22. Name and Address of Facility M00986 Cremation and Funeral Alternatives 8717 Green Pastures Dr. Baltimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Friysician HEART FAILUNE CONCIESTIVE YEAR /Medical Due to (or as a consequence of): Examiner FAY -1 PRIAL FIRRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, nding physician Physician/Medical the ! as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death P.O. F signed by the at d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ DEMEMTIA 1 Yes 2 No 3 Probably 4 Winknown should b Completed DO THIZOIDISM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificate 1 Yes 2 No or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20061765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) QUAINOU MO 3350 WICKENS AVE BALTIMORE MD ZIZZG 32. Registrar's Signature State NOV 3 0 2004 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 26, 2004 10:45 ам **Physician** Marie Linderman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore 109 Shady Nook Court If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
March 22, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 M 2 F 1922 Maryland Director 82 213-16-3355 Usual Residence of Decedent permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic event. Its M. Ciral Examinary. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 ☐ No Baltimore Baltimore Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 109 Shady Nook Court 21228 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: Specify: 3 ₩idowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frances Nejedlik Mag1ov John 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 109 Shady Nook Ct., Baltimore, MD 21228 Jacquelyn M. Priest 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 11/30/04 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 23a. Partitioner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HUTZ2 **Physician** SUDDEN DEATH /Medical Due to (or as a consequence of): Werrs Examiner CANDIOVAJUES Hypentensus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transil ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed: 1 ☐ Yes 2 ☐ No 1 Yes 2 № No certificate Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 📋 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 -Natural 5 Pending 1 Yes 2 No investigation 2 Accident Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ED/16 WHA 30. Name and address of person completed cause of death (Item 23a) (Type, Print) Columbia SDioner 11055 Little 32. Restrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 9 2004 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mantal Hygi & O. 1. 27700

Physici /Medi	0.00	1 - State Unpend Item Registrar  1. Decedent's Name (First, Middle, L	ast)				2. Date of Death	1	3. Time of Death
	cal	4a Equilibrations (If and in the street		ayne Lech			NOVEMBE	R 19, 201	
Examir	ier	4a. Facility Name (If not institution, gr JOHNS HOPKINS BAY	VIEW MEDICAL	CENTER	4b. City, Town, o	r Location of Death  ORE		4c. County of I	Death N/A
Funeral Director		217-69-6163	Sex 7. Age (In	n yrs. last bîrthday) Yrs.	If Under 1 Year Months Days 6 6	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 14,2	Year) 9. 2004 I	Birthplace (State or Foreigr Country) Maryland
show		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Loc	ation				10d. Inside City Limits
23a or 28a-f shov usi ke ncilihod at	tor	Maryland Bal	timore			D <b>u</b> ndal	k		1 ☐ Yes 2X No
or 28	Director	10e. Street and Number			10f. Zip Code	2011002		g. Citizen of Wha	it Country?
		7843 St. Fabia				21222		United S	States
Examiner	by Funeral	11. Marital Status  1本 Never Married 2  Married  3  Widowed 4  Divorced	12. Was Decedent Ever Amed Forces? 1 Yes 20 No If Yes, Give Year or Dates:	lf.	/as Decedent of H Yes, specify Cuba ☐ Yes 2 XNo	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
alical Ex	Completed	15. Decedent's E	Education	16a. Decede	ent's Usual Occup	ation	1	6b. Kind of Busine	White ess/Industry
A Marie	nple	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	(Give k	and of work done of O NOT use retired	during most of workii d)	ng		,
H. ES	S	0		De	pendent			N/A	
natic evar	To Be	17. Father's Name (First, Middle, Last)  Roy E. Lechner, Sr.  18. Mother's Name (First, Middle, Maiden Surname)  Denise M. Sims							
ar traun		19a. Informant's Name/Relationship Mr. Roy Lechner		19b. Mailing 7843	St. Fab	and Number or Rura pian Lane	Route Number, Dunda1k	City or Town, Stat , Maryla	te, <i>Zip Cod</i> e) and 21222
any injury or other traumatic event, it w Mudical once.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speci	Removal from State	Ob. Place of Disposi cemetery, crema Oak Lawn	atory`or other plac	e)		oc. Location - City Baltimor	or Town, State
any in		23a. Part 1. Enter the disease, or constock, or heart failure. List only Immediate Cause (Final	Masser	7	922 Wise	ss of Facility Funeral Ave. D g, such as cardiac of	undalk.	Maryland	Inc. 21222 Approximate Interval Between Onset and Death
as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cor  c. Due to (or as a cor  d.	nsequence of):					
	≥	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3□E	ctopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
ac	d l	Part II. Other significant conditions	contributing to death but not	resulting in the und	erlying cause give	n in Part I.	23e. Did tobac	cco use contribute	
pe o	Ω				only ing oddoo givo			2 No 3	e to the cause of death?  Probably 4 □Unknown
has baen signe ge 2 should be c	Completed b							24b. Were prior t	Probably 4 Unknown autopsy findings available to completion of cause of
s certificate has baen signe director, page 2 should be c	o Be Completed b	25. Was case referred to medical examiner?	Hospital:	2 X ED/Outpating		26. Place of Death	1 Yes  24a. Was an autopsy performe Yes 2 (Check only one)	24b. Were prior to death	Probably 4 Unknown  autopsy findings available completion of cause of escale 2 No
Il director, page 2 should be o	To Be Completed b	examiner?  1 Xres 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2∑ER/Outpatient pk 28b. Time of to Injury	3 DOA Othe	26. Place of Death	1 Yes  24a. Was an autopsy performe Yes 2 (Check only one)	24b. Were prior to death local loca	Probably 4 Unknown autopsy findings available to completion of cause of the second sec
<b>biractor:</b> After this certificate has baen signe n by the funeral director, page 2 should be o	Certification: To Be Completed b	examiner?  1 X/es 2 No  27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	nk28b. Time of U	3 DOA Othe  ink 28c. Injury Work  M 1 Y	26. Place of Death  T. 4 □ Nursing Hom  at 28  7  es 2 <b>X</b> No	24a. Was an autopsy performe Yes 2 [Check only one)  e 5 Residence  3d. Describe how	24b. Were prior to death 1 Prior to deat	Probably 4 Unknown autopsy findings available to completion of cause of the second sec
ieral Diractor: After this certificate has baen signe filled in by the funeral director, page 2 should be o	edical Certification: To Be Completed b	examiner?  1 Xyes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  2 Accident investigation  3 Suicide 4 Homicide GX Could not be determined	28a. Date of Injury (Month, Day Ye	At home, farm, street	3 DOA Othe  ink 28c. Injury Work  M 1 Y  t, factory, office	26. Place of Death  7. 4 Nursing Hom at 7. 28 6es 2 XNo unk 28	24a. Was an autopsy performe Yes 2 (Check only one)  e 5 Residence  Bd. Describe how  31. Location (Stree City or Town, S	24b. Were prior to death and Number or state)	Probably 4 Unknown  autopsy findings available to completion of cause of es 2 No  pecify)  Ink  Rural Route Numbe IIIK
n by the funeral director, page 2 should be o	Medical Certification: To Be Completed b	examiner?  1 Xyes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  2 Accident investigation  3 Suicide 4 Homicide GX Could not be determined	28a. Date of Injury - A building, etc. (Sp injurier: On the bast of my niner: On the basis of examand manner stated.	At home, farm, street becify)  knowledge, death onination and/or investigation.	3 DOA Othe  1nk 28c. Injury Work  M 1 Y  t, factory, office  ccurred at the time stigation, in my opi  29c. License O.C.N	26. Place of Death  4  Nursing Hom  at 28  7  es 2 XNo  unk 28  9, date and place, ar inion, death occurred	24a. Was an autopsy performe Yes 2 [(Check only one)] e 5 [ Residence and Describe how] at Location (Street City or Town, Stand due to the cause of at the time, date 29d.]	24b. Were prior to death and Number or state)	Probably 4 Unknown  autopsy findings available to completion of cause of escales 2 No  pecify)  The Course Number Unit (Street Course)  as stated.  ue to the cause(s)

ROSE MILLER

8:00 p.m.

NOVEMBER 27, 2004

			Indelible Ink. Ensure epartment of Health and Certificate of Death	Mental Hygie	•
Physic /Med	ical	1. Decedent's Name (First, Middle, Last)  Rose J. Miller			Day Year 3. Time of Death 8:00 p M
Exami Funeral Director		4a. Facility Name (If not institution, give street and number)  Stella Maris  5. Social Security Number  1 □ M 2 ☑ F  90  90	Months Days Hours Mir	s. 8. Date of Birth	4c. County of Death  Baltimore  9. Birthplace (State or Foreign Country)  1913 Maryland
e Maryland Se-f show	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town  Md. Harford	Forest Hill		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
21215-0036  Within 72 hours after deeth with the Maryland piene. In then "naturel", or Itama 23a or 28a-1 show the Madical Examiner must be notilized at	Funeral Director	10e. Street and Number  1914 Bear Creek Drive  11. Marital Status 12. Was Decedent Ever in U.S.	10f. Zip Code 21050  13. Was Decedent of Hispanic Origin?		g. Citizen of What Country?  U.S.A.  14. Race - American Indian,
0036 hours after of ural', or iten	D S	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (if Yes, specify Cuban, Mexican, Pue		Black, White, etc.  Specify: white
within within then	Completed	(Specify only highest grade completed)	ecedent's Usual Occupation Sieve kind of work done during most of w fe. DO NOT use retired)  ch press	orking	Sb. Kind of Business/Industry Western Electric
ore, Maryland 21215-0036 es 1 and 2 should be filed within 72 hours at of Heelth and Mental Hygiene. If them 27 is marked other than "natural" or re other treumetic event, the Madical Exert	To Be (	17. Father's Name (First, Middle, Last)  James Jamison  19a. Informant's Name/Relationship (Type, Print)  19b. Name/Relationship (Type, Print)	18. Mother's Na  Anna  Mailing Address (Street and Number or F		
4 8 E E		Debbie Ingram/granddaughter 19	14 Bear Creek Driv	e, Forest	Hill, Md. 21050 c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Depertment of Hee Importent: If Item eny Injury or othe once.		'4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licens e	n Cemetery 11/ 22. Name and Address of Facility Schimunek Funera		Bel Air, Inc.
Physician		23a. Part. Enter the disease of complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. CONGESTIVE HEAR		Road, Belac or respiratory arres	Air, Md. 21014 Approximate Interval Between Onset and Death
ate be executed  ate be executed  mysicien and  the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence	:		
F.O. BOX 68/10 hat the death certificate I d by the attending physisteletached for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yas 2 ▼ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
	by	Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.		cco use contribute to the cause of death?  2 \( \text{No} \) 3 \( \text{Probably} \) 4 \( \frac{\frac{1}{3}}{2} \text{Unknown} \)
- (0 LT	e Completed	25. Was case referred to medical	20 River (D	24a. Was an autopsy performe 1 Yes 2	
yeicie yeicie is cert	0 8	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outp	Other	eath (Check only one) Home 5 \( \text{Residence} \)	e 6 NOther (Specify) HOSPICE
on of	Certification; T	27. Manner of Death  1 X Natural 5 Pending (Month, Day Year) 28b. Tin (Month, Day Year)	ne of 28c. Injury at	28d. Describe how	
DIVISION SITE OF Attentions after death or after death or after death or after death or after or after in by the or after or afte		4 Homicide determined building, etc. (Specify)		City or Town, S	
To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, ( 2 Medical Examiner: On the basis of examination and/one)  29b. Signature and tile of certifier	feath occurred at the time, date and place or investigation, in my opinion, death occurred at the time.	urred at the time, date	se(s) and manner as stated.  and place, and due to the cause(s)  Date signed (Month, Day, Year)
2 3 2 8		1 12	D43725		11/29/04
51	ate	30. Name and address of person who completed cause of death (Item 23a) (Type DR. TARIO MAHMOOD 2300 DULANEY VA		1, MD 2109	3
Regist		NOV 3 0 2004 Beneva &	Space		

Mehemiah McOueen 04-07616 RKD

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

tate of Maryland / Department of Health and Mental Hygiers 0	11. 3	7	prior
Certificate of Death Reg. No.	14 0	) [	-

Hours

	- negistrar		
	1. Decedent's Name (First, Mi	ddle, Last)	
Physician /Medical	NEHEMIAH	MCQUEE	N
Examiner	4a. Facility Name (If not institu UNIVERSITY HO	-	number)
Juneral	5. Social Security Number	6. Sex	7. Ag

2. Date of Death NOVEMBER 26, 2004

702 3. Time of Death

UNIVERSITY HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) 10 M 2 ☐ F

4b. City, Town, or Location of Death BALTIMORE If Under 1 Year If Under 24 Hrs. Days

8. Date of Birth (Month, Day, 03.00. Min. 09.

9:05P. 4c. County of Death

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

1⊠Yes 2□No

Director

show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Mccical Examiner must be notified at

Director Funeral þ Be Completed

with the Maryland death \ filed within 72 hours after permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ni any Injury or other traumatic event, The Media once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Examine Physician/Medical þ Completed Be 2 Certification: in by 1 filled Medical

transit. and use as the burialthe attending physician ģ signed by t d be detach this certificate has After death. the within 24 hours after deati To the Funeral Director:

death certificate be exec

P.O. Box 68760,

Division of Vital Records,

the Hospital or Attending Physician:

220.92.9787 Usual Residence of Decedent 10a. State 10b. County WD NIA 10e. Street and Number STREET 1101 BENTALOU 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 KNo If Yes, Give Year or Dates: 1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 TH GRADE

BALTIMORE 10f. Zip Code

10c. City, Town or Location

25

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:

Months

USA 14. Race - American Indian, Black, White, etc. Specify: BLACK

16b. Kind of Business/Industry

10g. Citizen of What Country?

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CLERK

CYNTHIA

ST.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RETAIL 18. Mother's Name (First, Middle, Maiden Sumame

17. Father's Name (First, Middle, Last)

LEON MCQUEEN

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service License

19a. Informant's Name/Relationship (Type, Print) CYNTHIA HARCUM

1 Burial 2 Cremation 3 Removal from State

1101 BENTALOU

LOUDON

20b. Place of Disposition (Name of cemetery, crematory or other place) PARK

BALTO. MO. 20c. Location - City or Town, State

HARCUM

12.02.04 BALTO. MO 22, Name and Address of Facility VAUGHN C. GREENE FUNERAL 5151 BALTO, NATL PIKE, BALTO. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

20a. Method of Disposition

/au

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?

25. Was case referred to medical

examiner?

3 🗆

29a. Certifier

Suicide

4 Homicide

9 Unknown

IF FEMALE:

Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):

NA

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 4☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

12 ★es 2 □ No

1 Yes 2 No 26. Place of Death Check on one

Hospital: 1 | Inpatient | 2X ER/Outpatient | 3 | DOA | Other: 4 | Nursing Home | 5 | Residence | 6 | Other (Specify) 1 X Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 1 Natural 5 Pending 26-04 investigation 2 Accident

30. Name and address of person who completed cruse of death (Item 23a) (Type, Print)

8:35PM 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 🗷 No

28d. Describe how injury accurred Declared Shot 28f. Location (Street and Number or Butal Route Number, City or Town, State) 2200 RIGGS AND Balfinuare, RUD

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatute and title

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

NOVEMBER 27,2004

State Registrar

R. HOF 31. Date filed (Month, Day, Year) NOV 3 0 2004

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

	_			DL.,G037,L	partment of Health 1/30/04dhb ertificate of Death			31100
Physici	an	1. Decedent's Name (First, Middle, I	Mears			2. Date of Dea Month	Day Year	3. Time of Death
/Medic	al	4a. Facility Name (If not institution, g		r)	4b. City, Town, or Location	of Death	4c. County of Deal	<u> </u>
Examin	er	2133 N. SMAL		STREET	-	DRE	N	IA
Funeral			Sex 7. /	Age (In yrs. last birthd	ay) If Under 1 Year   If Under Months   Days   Hours	7 24 Hrs. 8. Date of Birti Min. (Month, Day	h 9. Birt	thplace (State or Foreign
Director		215-16-7236	1 □ M 2 XF	34-Yrs	Months Days Floors	02 29	3/1920	MD
and *		Usuel Residence of Decedent  10a, State 10b, County		10c. City, Town o	Location	· ·	1	10d. Inside City Limits
Maryli febo	ō	MD N	IA	BAL	MORE			1⊠Yes 2 No
death with the Maryland ms 23a or 28e-f ehow Imust be notilled at	rec	10e. Street and Number			10f. Zip Code		10g. Citizen of What Co	ountry?
th with		2133 N. SMAL	LWOOD S	STREET	21214	0	U.S.	<b>4</b> .
	Funeral Director	11. Marital Status	12. Was Deceder Armed Forces		Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	rigin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - Ame Black, Whit	
hours after turel; or ite	by Fu	1 Never Married 2 Married	I 1 ☐ Yes 2 ☐ If Yes, Give	Masio	1 ☐ Yes 2 XNo Specify		Specify: Bl	
72 hours "naturel",	q pa	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's	Year or Dates	16a De	cedent's Usual Occupation		16b. Kind of Business/	
uln 72 nin 72	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed)	(G	ive kind of work done during mos e. DO NOT use retired)	st of working		
Id ZIZI stiled within I Hygiene. other than "	mo	12th grade	College (1-40	1 34)	TECHNICIAN	J	WESTERN	<i>electric</i>
be filed tel Hygie of other	Be C	17. Father's Name (First, Middle, La	st)		18. Moth	er's Name (First, Middle,		
should be marked of matic eve	2	WILL ENNIS			At	A BARNE	~	
Mary lating Z IZ 13-0030 d 2 should be filed within 72 hours at th and Mantel Hygiens. 17 is marked other than "naturel", or treumatic event. The Medical Exam		19a. Informant's Name/Relationship	1 21 1		ailing Address (Street and Numb		1 -	Zip Code)
Heal Ther		20a. Method of Disposition	DHNS/DAU	20b. Place of Di	6 Palsley Court	Libum G	20c. Location - City or	Town. State
O 8,2 = 5		1 ⊠8urial 2 ☐ Cremation 3		cemetery, o	rematory or other place!	11.19.04	, -	
mit. Pa vartmen vortent: injury		<ul><li>4 □ Donation 5 □ Other (Special Service Licenses)</li></ul>		1 1 1 1				
Depariment of the part of the		17) and	, II—		22. Name and Address of Facil VAUGHN C. CY SISI BAUTIMOR	ene FUNC	EAL SERVICE	28. MD 21209
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/Medical		resulting in death)	aDue to (or a	astina is a consequence of):	Carcin	OTHIC		
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p is	lner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated greaters)	Due to (or a	is a consequence of):	- V			
and I-translt	Examiner	that initiated events resulting in death) Last		Is a consequence o :	telect of	30 C F.W	-177-	
te be executed ysiclan and e burial-transit	calE		·		59			
			d					
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death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☑ No		at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
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	Con		J			perfor	med? death? 2 No 1 ☐ Yes	257 No
Physiclen: r this certificate rail director,	Be	25. Was case referred to medical examiner?	Hospital:		Other	e of Death (Check only or		-
	10	1 Yes 2 No	1 □ Inpa	tient 2 ☐ ER/Outpa ijury 28b. Tim	HALL SO DOX 4	ursing Home 5 Besid	ence 6 Other (Spec ow injury occurred	cify)
After fune	tlon	1 Natural 5 Pending 2 Accident investigat	28a. Date of Ir (Month, E	Day Year) Inju			,,	
Mtendly death. ctor: A y the fu	flca	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of I	njury - At home, farm,	street, factory, office		treet and Number or Ru	ıral Route Number,
y to day	핕	4  Homicide	building,	etc. (Specify)		City or Tow	n, State)	
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To the Hospitel or Att. within 24 hours after de To the Funerel Direct completely filled in by It	Medical Cer	(Check only 2 ☐ Medical Expone)  29b. Signature and title of certifier  30. Name and address of person when the control of the certifier of t	and manner	death (Item 23a) (Ty				
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To the Hospitel within 24 hours To the Funerel completely filled	ite	(Check only 2 ☐ Medical Expone)  29b. Signature and title of certifier  30. Name and address of person when the control of the certifier of t	and manner  Cut  gcompleted cause of	death (Item 23a) (Ty				

State of Maryland / Department of Health and Mental Hygien 37704 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Miller November Alice 27, 2004 1:47 Ruth /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel 603 Forest Walk Lane #103 Odenton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** 1 M 20 F 73 Yrs. Director 065-24-9177 Feb. 07. New York Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir then "natural", or iteme 23e or 28e-f show the Medical Examiner must be notified at Yes 2 No Director Odenton Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 603 Forest Walk Lane #103 21113 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within a Department of Health and Mentai Hygiene. Important: if I tem 27 is marked other then any injury or other transmets. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (unknown) Isabelle Wildermuth ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 603 Forest Walk Lane #103 Odenton, Maryland 21113 Ralph E. Miller/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 12/1/2004 Crownsville, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lieensee Donaldson Funeral Home & Crematory, P.A. yanta P thomas MOO957 1411 Annapolis Road Odenton, Maryland 21113 Approximate Interval Between Onset and Death 23a. Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 6 monthes disease or condition Glioblastoma Multiforme /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transil the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2√ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 【☐ No 24a. Was an has page 2 mea? 2 No certificate 1 Yes Attending Physician: Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 | Inpatient examiner? Other: 4 Nursing Home 5 x Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident in by the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled within 24 hours To the Funerel 1 🖄 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. lhe l 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 131607 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George B. Cavanagh, M.D. 4201 Mitchellville Road Bowie, Maryland 20716 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 3 0 2004

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death <sup>Day</sup> 2004 Month **Physician** Robert Thomas Matthews Year 24, Nov. 2:42p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 820 Hidden Bluff Circle Catonsville Baltimore 7. Age (In yrs. last birthday) 81 vra 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/12/1923 9. Birthplace (State or Foreign Country)
MD • Funeral Days Months Hours Min 1 13 M 2 □ F 219-16-4167 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow injury or other traumatic event, the Medical Examinar must be notified at Catonsville MD. Baltimore 1 ☐ Yes 2 1 No Director 10e. Street and Number 820 Hidden Bluff Circle 10f. Zip Code 10g. Citizen of What Country? ŏ 21228 or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐¥es 2 ☐ No If Yes, Give Year or Dates: WWII. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygier 7 is marked other th antique curator antiques 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Paul Matthews, Sr. Rose Elmira Sears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traum 4 Moss View Court, Catonsville, Md. 21228 Thomas Paul Lyons - nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Woodlawn Cemetery 11/27/04 Woodlawn, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, 736 Edmondson Ave., Catonsville, Md. 21. Signature of Funeral Service Licensee Inc. 21228 Standa demmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician GASTROINTESTINAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9☐ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Onknown BUTICAGUYATION Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy DEED VENUUS THROM KUSIS certificate 1 Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home Selection 6 | Other (Specify) 2 P 1 🗌 Yes this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 050303 30. Name and address of person who ambleted cause of death (Item 23a) (Type, Print) ctonsville MD SHP 162 455 Frederick 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 3 0 2004 Registrar

			1_ State	State of Maryland	Department of H		ental Hygier Reg. 1	Z U U 4	37706	
ı	Physici	an	1. Decedent's Name (First, Middle, Last)	INU MCI	Oan		2. Date of Death	Day 71 7(Y)	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give style	et and number)	4b. City, Town, or	r Location of Death	City	4c. County of Death	WeCount	
	Funeral Director		unknown	7. Age (In yrs. last	birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min	8. Date of Birth (Month, Oay, Yea 2	ar) 9. Birth	nplace (State or Foreign ) untry) M 19	
	show	٥٠	Usual Residence of Decedent  10a. State  10b. County		own or Location				10d. Inside City Limits 1  Yes 2  No	
	death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number  961 MC KEAV	11.6 21	10f. Zip Code	7	10g. (	Citizen of What Con	untry?	
		Funeral		Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give	13. Was Decedent of Hilf Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White		
3-003e	72 hours after "natural", or Ite	leted by	3 Widowed 4 Divorced  15, Decedent's Educat (Specify only highest grade of	Year or Dates:	6a. Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired	ation	16b.	. Kind of Business/I	Industry	
7170	be filed within 72 tal Hygiene. d other then "na event, Ihe W. dic	e Completed	Elementary/Secondary (0-12) C  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	NONE	18. Mother's Name		len Sumame)		
ylan	D @ 25 0	To Be	unknown	Brint	19b. Mailing Address (Street a	ZANE.			6MAS	
, Mai	s 1 and 2 shou if Health and M item 27 is mar other traumat		19a. Informant's Name/Relationship (Type  ZAN EIN Thom	1As	961 MC [] e of Disposition (Name of	EAN AL	VE 212/	6 BAIts	MA	
HOLE	Pages 1 lent of H nt: if ite ry or otl		20a. Method of Disposition   1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren   '4 ☐ Donation 5 ☐ Other (Specify)	oval from State	etery, crematory or other plac Lawn Cemetery			odlawn.		
Ball	permit. Departrimporta Importa any inju		21. Signature of Funeral Service Licensee	erkins	22 Name and Address Sterling		ıwab Funei	ral Home,	Inc.	
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	/Medical Examiner		resulting in death)	Due to (or as a consequen	ice of):	)				
8760,	certificate be executed nding physician and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	- membr	anes	fivedays				
O. Box 68	death e atter	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deati 9 □ Unknown	ath 3 Ectopic pregnancy	,		23d. Date of delin	very Day Year	
ds, P.	requires that the der been signed by the a hould be detached f	ě	Part II. Other significant conditions contri	- 11 -	ng in the underlying cause give	en in Part I.	23e. Did tobacc		the cause of death?	
Vital Records,	e law has b	Completed					24a. Was an autopsy performed	prior to c death?	topsy findings available completion of cause of	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	pital:	Woutheright 3C DOA Oth	26. Place of Death	(Check only one)			
ō	nding Phys th. : After this s funeral di	ıtlon; To	1 Tes 2 No	1 Lumpatient 2 LEH	Bb. Time of Injury Work	vat 2	ne 5 Residence 8d. Describe how in		iny)	
Division	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specily)	a, farm, street, factory, office					
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (	29a. Certifier 1 Check only one) 1 Heartifying Physic 2 Medical Examine	ian: To the best of my knowler: On the basis of examination and manner stated.	edge, death occurred at the time and/or investigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cause od at the time, date a	n(s) and manner as and place, and due	stated. to the cause(s)	
	To the within To the Compl	Me	29b. Signature and title of certifier.	, Ochry	MMD 29c. Licenson P 16	UEA		Date signed (Month	n, Day, Year)	
			30. Name and address of person who com	pleted cause of death (Item 23	Mero	ymed	ical Ce	inter	301 St. Paul Aug	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. registrar's Signatu	x spera					

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Division of Vital Records, P.O. Box 68760,	tal or Attending Physician: The law requires that the death certificate be executed start death.	in and proceder. After this certificate has been signed by the attending physician and ed in by the funeral director, page 2 should be detached for use as the burial-transit

ciar		1. Decedent's Name (First, Middle, Last)  Nelda Aretta  Nelda Avetta	Moody			-	2. Date of Dea Month	ath 1	1/23	3. Time of Dea
lica ine	-	4a. Facility Name (If not institution, give s			4b. City. Town. o	r Location of Dea	11111		Ounty of I	1:58 a
nie	ı	Laurel Regional H			Laure					e Georges
1		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h V Year	9.	Birthplace (State or For Country)
r	-	421-09-2322	<sup>1M 2</sup> ∏ F 94	Yrs.	Days	110010	Feb. 1	19		Mississippi
	-	10a. State 10b. County	10c. City,	Town or Loc	ation					10d. Inside City Lir
100	5	MD Montgome	ry Silv	er Spr	ing					1 ☐Yes 2 ☐
Director		10e. Street and Number			10f. Zip Code			10g. Citi	izen of Wha	t Country?
0		3009 Fallston Av			2090				Unite	ed States
Firmores	3	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)			American Indian, White, etc.
ì	5	3 □XVidowed 4 □ Divorced	1 □Yes 2X No If Yes, Give Year or Dates:	1	☐ Yes 2☐xNo	Specify:			Specify:	white
hote		15. Decedent's Educ (Specify only highest grade	cation	16a. Decede	ent's Usual Occup	ation		16b. Ki	nd of Busin	ess/Industry
Completed		Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired	during most of wo	nking			
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Ro	<b>i</b>	William Jefferson	Faulkner			Pearl	me (First, Middle, Anola_	Fer	crell	Faulkner
F		19a. Informant's Name/Relationship (Type		19b. Mailing	Address (Street	rearr and Number or R	Anola F ural Route Number	City o	r Town. Sta	tulkner
		Joseph Rose/ son					Silver			
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	0.00	e of Disposi	tion (Name of atory or other place					or Town, State
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		21. Signature of Funeral Service License	1 Lallan	/ 22 R	Name and Address	ss of Facility	Crematio	n Se	rvice	S
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		23a. Pan1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	Do not enter	the mode of dyin	g, such as cardia	c or respiratory arr	est,		Approximate Interval Between Onset and Death
	-	disease or condition resulting in death)	Pneumonia							
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î		resulting in death) Last	Due to (or as a consequer	nce of):						
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Physician/Med		IF FEMALE: 23b. Was decedent pregnant 23	sc. If yes, outcome of pregnanc	v					24 0-11	4-1:
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2		9 🗆 Unknown	9□ Unknown							
by P		Part II. Other significant conditions cont	ributing to death but not resulting	ng in the und	erlying cause give	en in Part I.	23e. Did tob	oacco us	se contribute	e to the cause of death?
	-	Osteoporosis					1 □ Ye	s 2	]No 3 □	Probably 4 Unkno
Completed	.   _						24a. Was a		24b. Were	autopsy findings availate completion of cause of
							perform 1 ☐ Yes 2	ned? ∑∏No	death 1 🗆 Y	1?
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Certification:		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, tarm, stree	t, tactory, office				Number or	Rural Route Number,
Cer			Sullang, Sto. (Specify)				City or Town	, State)		
ical	1	29a. Certifier 1 Certifying Physi (Check only 2 Medical Exemin	cian: To the best of my knowle	dge, death o	ccurred at the tim	e, date and place	, and due to the ca	use(s) a	and manner	as stated.
Medical	-	29b. Signature and little of certifier	and manner stated.							
	-	VERNILO M	10. Alterest	US	29c. License	2580				onth, Day, Year)
		, isincy a.		1.	D42	2380	I.	love	mber 2	23,2004
	3	30. Name and address of person who con	pleted cause of death (Item 23	a voe De	int)					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Year Moran Va 11:40PM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MD Care Essex Kiverview Baltimore 5. Social Security Number If Under 24 Hrs. If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
MARYLAND 8. Date of Birth Funeral 1 M 2 XF Months Days Hours 218-12-8787 80 19,1924 Director MARCH Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location r than "netural", or items 23a or 28a-f show tre Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director MD. N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 228 N. ELLWOOD AVENUE 21224 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 Nidowed 4 Divorced Specify: WHITE Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 SALESPERSON FURNITURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be √ 1 a... of Health and if item 27 is marked. `~ar treumatic ev and Mental FOSTER FRANK BRESE 2 KABAT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILFORD A. MORAN/ 228 N. ELLWOOD AVENUE, BALTO., MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If It any injury or once. 6 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST V.A. 12/6/04 OWINGS MILLS, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Musocus preventa Examiner Due to (or as a consequence of): certificate be executed ettending physician and for use as the burial-transit Physiclan/Medical Exami Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Box 68760, Due to (or as a consequence of): use as t ate hes been signed by the e page 2 should be deteched t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Honkilown The law requires that alscen Division of Vital Records, <u>م</u> 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed colon carcinoma this certificate hes prevuoria 1 obabel 1 🗆 Yes 2 HO 1 ☐ Yes 2 ☐ No. Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☑ Hursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 Yes 2 JNO 27. Manner of Death 1 Natural Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours after To the Funeral Director Completely filled in by 4 🗌 Homicide 29a. Certifier (Check only one) 1 Deertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D1966 Megel 11-29-2004

7310 RITCHIE, HIGHWAY, BALTIMORE, MD. 21061

books

es alles

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SCHWARTZ

State Registrar MICHAEL

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 10d, f, 19b, per, fh, 839 1-18-05 vt. State of Maryland / Department of Health and Mental Hygiege 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ALBERT COLONNA WALEWSKI MONTAGUE 27 NOV. 2004 /Medical 3:10a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6006 CHARLESMEAD RD BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/27/1933 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1**№** M 2□ F 048-32-2886 Director 71 Yrs. POLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural; or items 23a or 28a-1 ehow any injury or other traumatic event, It. Muritial Examination 2000. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MDBALTIMORE -1949 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 6006 CHARLESMEAD RD 21210 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 5 + College (1-4or 5+) Elementary/Secondary (0-12) PHYSICIAN MEDICAL DOCTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be TADEUSZ ZDANOWICZ KARINA COLONNA WALEWSKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6006 CHARLESMEAD RD BALTO., MD. 21210.21212 SERENA MONTAGUE (WIFE) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) CH. OF THE REDEEMER12/10/2004 BALTO. CITY, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W. JENKINS & SONS CO. YORK RD MONKTON, MD. 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): 1 months disease or condition resulting in death) utun discosa 10/1013 Coronery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ chabetes nellity; 3 ☐ Probably 4 Zunknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 Yes 2 No

/Medical Examiner use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be execu Box 68760, nding physician P.O. Division of Vital Records, this After death. within 24 hours after death To the Funeral Director:

Certification: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lichardo Berg, aD 020604 11/25/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD BERG 10755 FALLS RD.

31. Date filed (Month, Day, Year) State NOV3 0 2004 Registrar

32. Registrar's Signature

#450 TIMONIUM, MARYLAND 21093

To the

			1 - State of Maryland / De State of Maryland / C	partment of Health and M ertificate of Death	lental Hygie	
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physic /Medi		BETTY KEATING MYERS		November	25, 2004 9:17 P.M
	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Gilchrist Center	Towson		Baltimore
	Funeral Director		5. Social Security Number  6. Sex 1 □ M 2 ▼ 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda 7. Age (In yrs. last birthda	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 27,	9. Birthplace (State or Foreign Country) 1932 Washington D.C
	pur M		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location		
	ith the Marylan or 28a-f show	ក				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the M	Director	Maryland Baltimore Luther  10e. Street and Number			
	with a or	ā		10f. Zip Code	10g.	. Citizen of What Country?
	eath	erai	13 Westbury Road  11. Marital Status 12. Was Decedent Ever in U.S. 13	21093		U.S.A.
	ter d Iten	Funeral	1 Never Married 2 Married In U.S. Armed Forces?  1 Never Married 2 Married If U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto</li> </ol>	Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
366	urs al	b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give A Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: White
21215 0005	If I I I I I I I I I I I I I I I I I I	Completed	15. Decedent's Education 16a. Dec	cedent's Usual Occupation	166	b. Kind of Business/Industry
5	thin 7	ple	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of worki DO NOT use retired)	ng	•
5	or th	no.	12 years	Homemaker		Own Home
7	Individual within 72 hours after death with the Maryla 2 should be filed within 72 hours after death with the Maryla and Mental Hygiene.  Is marked other then "natural", or Items 23a or 28a-f show aumatic event, if a Mudical Examiner must be notified at	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai	den Sumame)
5	should be in a Mental I is marked o	2	John Bruce Keating		nne Bark	
	2 sh and Is m			iling Address (Street and Number or Rura		
	he a a		Karen L. Myers-Zauner (dtr.) 5270	) Five Fingers Way		
	ges 1 ar t of Hea If Item 3 or other		20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 20b. Place of Discemetery, ci	position (Name of pematory or other place)	ate 200	. Location - City or Town, State
3.	. Pa men tent: jury		'4 □Donation 5 □ Other (Specify) Green Mo	ount Crematory 11-	26-04 Ba	ltimore, Maryland
, , , , , , , , , , , , , , , , , , ,	permit. Pages 1 Department of H Importent: if ite any injury or ot		21. Signature of Funeral Service Licensee	22. Name and Address of Facility 11tchell-Wiedefeld 6500 York Road	Funeral H	Iomo Tac
			Act a first to the	0000 TOLK ROad De	artimore,	Maryland Ziziz
3			23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac o	r respiratory arrest,	
0	Pnysician	é v	Immediate Cause (Final disease or condition	Multitorne		Onset and Death  MONTHS
1	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	1 11411		11816113
===	Examino	_	Sequentially list conditions, b.			
0 1 1	Sit 9d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
@ \$	ecut and I-tran	хап	c. Due to (or as a consequence of):			
10d	icate be executed physician and sthe burial-transit	三田	Due to (or as a consequence of):			
0 0	8 g =	edicai	d			
35			IF FEMALE: 23c. If yes, outcome of pregnancy			
&	of the state of	Physician/M	in the past 12 nonths?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year
- 0	the d	ysic	1 ☐ Yes 2 █ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Citier (specify)		
۵	signed by the a		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	to use contribute to the cause of death?
Myers	uiries sign ld be	d by				2 □ No 3 □ Probably Dinknown
ع کے	w requir been si should	Completed				
کی او	The lay ate has page 2	E D			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
thy Myers			OF Weep and referred to market		1 Yes 2 X	
-문 5	Physician: this certific	Be c	25. Was case referred to medical examiner?  1   Yes   2√  No   Hospital: 1   Inpatient   2   FR/Outpatient   26. Place of Death		The season	
2 6	Phy r this	To	1	ant 3 Don 4 Intrising non	ne 5 ☐ Residence 8d. Describe how in	
مري و	ding th. : After s funer	ţ	1 Anatural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation			nary occurred
Division	Attending r death.	fica	3 Suicide 6 Could not be	street, factory, office 2	8f. Location (Street	and Number or Rural Route Number,
ć	afte Dire	Certification;	4 Homicide determined building, etc. (Specify)		City or Town, St.	ate)
	bours nera y fille		29a. Certifier 1 Certifying Physician: To the best of my knowledge, des	ath occurred at the time, date and place, a	nd due to the cause	e(s) and manner as stated.
	To the Hospitel or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurre	d at the time, date a	and place, and due to the cause(s)
	To t withi To tl	Ž	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month, Day, Year)
		/	Juson Kach	00061199	0	Lou 26 2004
	1,2	1	30. Name and address of person who completed cause of death (Item 23a) (Type			
_	\			n Charles ST	Touson 1	(4) 21204
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	/ " »» <u> </u>		
	Registr	ar	NOV 3 0 2004 Beneva	I don't		

State of Maryland / Department of Health and Mental Hygien 001 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 19 Physician 2004 November Robert Owen 7:25 PM /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** TOWSON

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Greater Baltimore Medical Center Baltimore

9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 2 M 2 ☐ F 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** NONE MΩ Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at Ba Reisterstown 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò USA 21136 or items 23a Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Yes 2 □ No Specity: Unknown þ Specify: 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Magnetic accept. College (1-4or 5+) Elementary/Secondary (0-12) NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Madden omas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 2004 \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LIENRY SONS CO ONA CO RD. MONKTON 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physicien ar s the burial-t Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. 1 the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? page certificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) I in by t 4 - Homicide within 24 hours after To the Funeral Dire Medical 1 🗓 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mesno 1)26112 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 31. Date filed (Month, Day, Year) 32. Regularar's Signature State NOV 3 0 2004 Registrar

				partment of Health and Meartificate of Death	Reg.	211114 31112
	Physici		PARKS HOWELL MAXWELL		2. Date of Death Month	Day Year 3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give street and number) PENINSALA REGIONAL MEDICAL CENTRAL	4b. City, Town, or Location of Death	Nov.	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 252–20–0600 81 Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 8 / 24 / 1923	9. Birthplace (State or Foreign Country) GEORGIA
4000	28a-f ehow	Director	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or   MD   ANNE   ARUNDEL   GLEN   BUR   10b. Street and Number   10c. S		100	10d. Inside City Limits 1 □ Yes 2X□ No Citizen of What Country?
đ địng	23a or	al Di	612 NOLBERRY DRIVE	21061		S.A.
3-003b		by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced  12. Was Decedent Ever in U.S. Amped Forces?  1 ☒ Yes 2 □ No If Yes, Give Year or Dates: 1945–46	Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto F     □ Yes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
0-61212 b	jiene. r than "natu Ina Medical	Completed	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	sedent's Usual Occupation ve kind of work done during most of workin DO NOT use retired) RICT SALES MANAGER	g	OD DISTRIBUTION
/rand ,	h and Mental Hyg	To Be C	17. Father's Name (First, Middle, Last) GEORGE MARTIN MAXWELL	18. Mother's Name  ALLIE M.	(First, Middle, Maid	
, mar,	m 27 is me		MARY A. GLEADOW - NIECE 87 P.	iling Address (Street and Number or Rural EYTON STREET, DOVER		
	ment of ant or ury or		'4 □ Donation 5 □ Other (Specify) CHESAPEAI	SE CREMATION 11/30,	/2004 ST	Location - City or Town, State
	Depar Impor any in	appropriate to the second	21. Signal re of Euneral Servic Aicensee  23a Part. Enter the disease, or complications that caused the death. Do not e	22. Name and Address of Facility SIN( L SECOND AVE. S.W. (	GLEN BURN	NERAL HOME P.A. IE, MD 21061
ate he executed	hysician and hysician little prival-transit the prival-transit	dical Examiner	syock, or neart failure. List only one cause on each line.	E Respiratory to		Approximate Interval Between Onset and Death 3 wk (
The law requires that the death certific	ed by the attending pt detached for use as the	hysician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
duires that	been signed b	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	2 40 3 Probably 4 Unknown
The law re	is certificate has be director, page 2 sho	Completed	Coronary aftery disease Congective heart failure		24a. Was an autopsy performed 1 Yes 2	
V I C	certificate rector, pag	o Be	25. Was case referred to medical examiner?	26. Place of Death		
anding Physical	within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to	-	27. Manual of Death 1 Natural 5 Pending 2 Accident Accident Page 10 Pending Injury 2 Accident Page 10 Pending Injury 1 Natural 5 Pending Injury 2 Natural 1 Pending Injury 2 RevOutpate 2 ER/Outpate 2 E	e 5 ☐ Residence 3d. Describe how in	6 □Other <i>(Specify)</i> njury occurred	
ital or Atte	ours after death. Ineral Director: After th filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, St	
the Hosp	within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, der (Check only one)  1 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurred	at the time, date a	and place, and due to the cause(s)
To	¥ 5 8		29b. Signature and title of certifier	29c. License number  00041211	29d. [	Date signed (Month, Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Typi	o, Print)		11/24/04
	Sta Registr		St. Date filed (Month, Day, Year)  NOV 3 0 2004  Server A	SAlisbury, Md	. 21801	

DHMH 17 Rev 1/2001

MAXWELL, PARKS # 253-20-0600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] [] 1- State Registrar AMEND ITHM #8 PER FIT C838 12/07/04 Gertificate of Death 2. Date of Death November 25, 2004 Physician Lafayette McGuire, Jr. 6:30 pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 1935) | November 26, 2004 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F 212-32-7815 68 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f ahor the Medical Exemple Privat be rediffed at MD Baltimore Parkville 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 8820 Walther Blvd, #4107 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 □ No 55- 57
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes X☐ No Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a Foreman Bethlehem Steel marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) McGuire, Sr. J. Lafayette Sarah Β. Pear1 and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health an
Important: If item 27 is m
any injury or other 3769 Spring Meadow Dr., Ellicott City, MD 21042 Karen Frazier-sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem'l Park ¦ 12/1/04 Elkridge, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Savice censee William G. Dau 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Rd., Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Pnysician Due to (or as a consequence of) disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after deat To the Funeral Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title, of certifier 29c. License number nan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel air, mo Chesapeake Drive 500 Dr. Jeffrey A Upper 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Ourter! NOV 3 0 2804

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				For State Registrar	State	of Marylan		artment o				giene 0 0	L <sub>t</sub>	37714
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		Examin	er	4a. Facility Name (If not institution, gir		mber)		4b. City, Tow				4c. County o		
				North Arundel Ho 5. Social Security Number 6.	spital <sub>Sex</sub>	7. Age (In yrs. i	lace histoday)	Gle	en Burr	nie er 24 Hrs.	9 Date of Bird	Anne A		
		Funeral Director			1 □ M 2 🖔 F	63	Yrs.	Months Da			8. Date of Birt (Month, Da	y, Year) 5, 1941	Cour	olace (State or Foreign otry) China
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Sance,	Maryland	S C L I		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Str	reet and Num	ber or Rura	al Route Numbe	or, City or Town, S	tate, Zip	Code)
tion		and 2 ealth m 27		John W. Nance/ Hu	sband		518 J	Ann Dr	ive C			land 211		
	Baltimore,	Pages 1 nent of H int: If itel		20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 [	☐Removal from	State	emetery, cren	sition (Name of natory or other	place)		Date	20c. Location - C	ity or To	wn, State
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	Bal	permit. Pages 1 and 2 Department of Health s Importent: If item 27 li eny injury or other tre		21. Signature of Funeral Service Lice	Thoma	M009	5.7 D	onaldso	n Fune	eral F	lome & (	Crematory con, Mary	7, P	.A.
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		To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (	29a. Certifier 1 Certifying P	hysicien: To the	e best of my know	wledge, death	occurred at th	e time, date a	and place, a	and due to the o	cause(s) and manr date and place, an	ner as st	ated.
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		For State Registrar	State of	Maryland /	Depa <i>Cei</i>	artment of F	lealth a <i>Death</i>	and M		ene 0 0	4	37715
Physic	cian	Decedent's Name (First, Middle, Last)	)						2. Date of Death Month	Day	Year	3. Time of Death
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Exam	iner	ARUNDEL MEDICAI				ANNAP				ANNE	ARUI	NDEL
Funera	al	Social Security Number     6. Se	х 7. ] м 2ДF	Age (In yrs. last		If Under 1 Year Months Days	If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign ntry)
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land ow		10a. State 10b. County		10c. City, To	own or Lo	cation						10d. Inside City Limits
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or 28	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of V	Vhat Cou	intry?
eath v 18 23e	Funerai	110 CLAY ST.	12. Was Decede	ent Ever in U.S.	13. \	21401 Was Decedent of H	lispanic Orio	gin? (Spe	ecify Yes or No-	USA 14. Race	e - Amer	can Indian,
itter d writerr	Fun	1 ☐ Never Married 2 ☐ Married	Armed Force 1 ☐ Yes 2	es?		Was Decedent of H		, Puerto I	Rican, etc.)		k, White,	
ours a	À		If Yes, Give Year or Date			1 ☐ Yes 2 X No	Specify:			Specify		LACK
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od 2 st lith and 127 to r		MAKIETTA NICK (DA				-				-		ZLAND 21401
item other		20a. Method of Disposition		ceme	of Dispo	sition (Name of natory or other place	ce)	D	ate 2	Oc. Location -	City or T	own, State
Page ment c ant: If ury or		1 ☑Burial 2 ☐ Cremation 3 ☐ i `4 ☐ Donation 5 ☐ Other (Specify,		are	SATE	CEMETERY	11					MARYLAND
parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show eny injury or other traumatic event, the Medical Examiner roust be notified at	ODC	21. Signature of Funeral Service Licens  Larry A. Re	ese MOU	483		2. Name and Addre						JARY, P.A.
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DIVI	Certification:	4 Homicide determined	286. Place 0	g, etc. (Specify)	, rarm, str	eet, factory, office		1	28f. Location (Str City or Town,		er or nur	ar noute Number,
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To the within To the	Me	29b. Signature and title of cedifier	OP	00 00		29c. Licens	se number		29	d. Date signed	J (Month,	Day, Year)
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900	within 72 hours after death with the Maryland liene. r then "naturel", or Items 23a or 28e-1 show the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			s Decedent of H es, specify Cuba Yes 2X No	ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		4. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	within liene. r then "	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)		-)	(Give kir. life. DO	nt's Usual Occup od of work done of NOT use retired	during most of v f)	vorking		nd of Business	/Industry
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	ges 1 and 2 should t of Health and Mer If item 27 Is marke or other treumatic		19a. Informant's Name/Relationship George W. Hipp (1		law)	223 G	Address (Street a lenrae I on (Name of		Rural Route Number	1e, N	larylan	d 21228
Baltimore,	t. Pa rtmen rtent: rjury		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Spec	eify)	ceme	ctery, cremat Cathed	ory`or other place Iral Cem	. 12-	1-2004	Balt		Maryland
Ba	permi Depa Impo any ii		23a. Part1. Enter the disease, or co		the death. D	Wit   163	zke Fun 0 Edmon	eral Ho dson Av	me of Cat e. Catons	consv svill	ille, e, Mar	Inc. yland 21228 Approximate
	Physician /Medical Examiner		shock, or seart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each line a Due to (or as a	Pnu	ren	noni		according to the second			Interval Between Onset and Death
	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, jusease or injury that initiated events	b. Due to (or as a	consequenc	ce of):						
38760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a	consequenc	e of):						
.O. Box 6	death certif e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal dea		topic pregnancy ther (specify)			23	3d. Date of del Month	ivery Day Year
ords, P	The law requires that the te has been signed by th bage 2 should be detache	by	Part II. Other significant conditions Diabetes	contributing to death but	not resulting	j in the unde	rlying cause give	en in Part I.		obacco us (es 2		the cause of death?
Vital Records,		Completed	Unemia Hypert	ension					1 ☐ Yes	rmed? 2 No	24b. Were au prior to death? 1 \(\sum \) Yes	topsy findings available completion of cause of
Division of Vit	Phys this ral dir	ertification; To Be	25. Was case referrer to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Matural 5 Pending investigating Suircide 6 Could not		28b	Outpatient  Time of Injury	3 DOA  28c. Injury Work  M 1 1	4 Nursing	eath Check onl o  Home 5 - Resid	dence 6		oify)
DIX	oital or Att urs after d ral Direct	O	4 Homicide determine	building, etc.	(Specify)				City or Tow	m, State)		ral Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Attercompletely tilled in by the funer	Medical	29a. Certifier (Check only one)  1 Certifying F 2 Medice! Exe	thysicien: To the best of eminer: On the basis of e and manner state	examination a	ge, death od and/or inves	courred at the tim tigation, in my op 29c. License	oinion, death oc	curred at the time, o	date and p	nd manner as place, and due signed (Monti	to the cause(s)
)	h 3 F 8		30. Name and address of person who	7/	Mn ath (Item 23a	1) (Type Prin	03	173	91 1		emlee	
	Sta	te	Ming Will 33 31. Date filed Month, Day, Year)	20 (Sens	'on /	Ave	nue	. 13a	timor.	e 1	Marylo	and zizz
DHI	Registr	- 10	WOV 3 0 2	204 James	par 1	A.	Sports	1		-7,111 7 2		

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 4 1 - For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 12:45a M John Matthew Ourednik NOV 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 802 East Broadway Harford If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1፟፟፟∭M 2□F 63 213-38-8373 1941 Director Maryland Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or 28e-f show treumatic event, the Medical Exercises must be notified at 1 ☐ Yes 2 No Directo Harford Bel Air Maryland 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene. snt: If item 27 le marked other then "naturel", or Items 23a or 2 21014 USA 802 East Broadway Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 M Yes 2 No 1958

If Yes, Give Year or Dates: 1961 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Federal Auditor Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tina Unk. William E. Ourednik 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Ourednik, Wife 802 East Broadway Bel Air, Maryland 21014 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/27/04 Metro Crematory Inc. Baltimore, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee
Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland 299 Frederick Road Baltimore, Maryland Inc. Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Jole Pnysician traphic 485 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and use as the burial-transi Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 2 **X** No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ determined 4 Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year)

State Registrar

Greene St 3414 32. Registrar's Signature

w

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12

3

29c. License number

146426

21201

29b. Signature and title of certifier

Fin

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 29,2004 Howard James Ortt 2:40A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Franklin Woods Nursing Home Rossville Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth April 10 6, 1917 Birthplace (State or Foreign Country) **Funeral** 215-01-0259 1 € M 2 □ F Days Hours 87 Director Maryland Usual Residence of Decedent 10b. County show 10c. City, Town or Location r 28a-f show 10d. Inside City Limits Baltimore Maryland Parkville 1 ☐ Yes 2 🔀 No Directo 10e. Street and Number 2314 Foster Avenue 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or Items 23a or. any injury or other traumatic event, the Middel Examination once. 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑Yes 2 ☐ No If Yes. Give WW II 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: WW II 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8 yr s College (1-4or 5+) Truck Driver Chemical Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph 0rtt Myrtle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph Ortt - Son 2314 Foster Avenue Baltimore, Maryland 21234 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
Moreland Memorial Park 12/1/04 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, MD \* 4 □ Donation 5 □ Other (Specify) <sup>22</sup> Name and Address of Facility Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 5305 Harford Rd 21. Signature of Funeral Service Licensee EKUBOCK 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition **Physician** ATHERO SCLEROTIC HEART /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical for use a IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ERIPHERAL VASCULAR DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No certificate 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 1 Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After the Hospital or Attending 5 Pending death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide hours after within 24 hours a To the Funerat Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 04000 30. Name/and address of person who completed cause of death (Item 23a) (Type, Print) 9105 FRANKLIN SQUARE DR. BALTIMURE PARSHALL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 3 0 2004 parker Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Deeth Month EVELYN PARTLOW 11 23-2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Brock Bridge Road 4c. County of Death Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Pennsylvania Days 036-26-1304 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Jessup 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 7943 Brock Bridge Road 20794 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Builder Automotives 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Μ. Wooten Velva Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Charles Wyatt /son 566 Chrome Road Rising Sun, Maryland 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/26/04 Odenton, Maryland West Arundel Crematory 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Licenses Momas uanita M00957 1411 Annapolis Road Odenton, Maryland 21113 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Rospiratory Faclure Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):

Static S mall Cell Llung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Ather (Specify) KRISON 3□ DOA 27. Menner of Death 28a. Date of Injury (Month, Day 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide

Box 68760, Division of Vital Records, P.O.

attending physician end I for use as the burial-transit been signed by the has this certificete After or Attending efter death.

Director: Aft
d in by the fur completely filled in by To the Hospital o within 24 hours ef To the Funeral D

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show

7 is marked other than "natural", or items 23s or traumatic event, the Medical Examples rust be

permit. Pages 1 and 2 should be filed withir Department of Health and Mentel Hygiene. Important: If item 27 is marked other than any injury or other traumatic avent, It a Me

**Physician** 

/Medical Examiner

Examiner

Physician/Medical

þ

Be

Certification:

Medical

8

page 2 should Completed

illed within 72 hours after

Maryland 21215-0020

Baltimore,

Funeral Director

2

Completed

Be

Registrar

GETACHENI 31. Date filed (Month, Day, Year) NOV 3 0 2004

29b. Signetura end title of certifier

4 - Homicide

29a. Certifier

TEFFERRA

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

7943 Brock-Bridge Road JESSUP, MARYLAND 20794

Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29c. License number

D0057218

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien 00 1 37720 For Stata Ragistra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** MARY THERESA PERVOLA 2004 11 27 6:23 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 208 Lake Rd Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9 10 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1□M 2XF 219 78 Yrs 20 5100 Maryland **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits if than "natural", or Items 23a or 28a-f show The Medical Examiner must be notified at 1 ☐ Yes 2 No MD Anne Arundel Pasadena Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 208 Lake Rd 21122 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary T. O'Leary Louis M. Yealdhall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6115 Kara's Walk Elkridge, MD Frank S. Pervola, Jr.-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1. Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Holy Cross Cem 11/30/04 Baltimore, MD injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, any ir 169 Riviera Dr. Pasadena, 23a. Part1. Enter the dise e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Z MOINTHS /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 XNo 9 □ Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) à signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 0 No 3 ☐ Probably 4 ☐Unknown 1 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page ; certificate 1 ☐ Yes 1 Tes To the Hospital or Attending Physicien: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending Natural 1 ☐ Yes 2 ☐ No investigation in by the I 2 Accident within 24 hours after deatl To the Funerel Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapfler stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 71826 30. Name and address of person who completed sause of death (Item 23a) (Type, Print) BALTIMORE JORNICE 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 3 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 27,2004 **Physician** NOV. Year WILLIAM PLITT 8:30 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** JOHNS HOPKINS HOSPITAL BALTIMORE N/A 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fig. Country) JULY 30,1918 MARYLAND 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours **X** 2 □ F 215-09-6233 Yrs. Director 86 Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is markad other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1X Yes 2 No **Funeral Director** MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 618 S. CURLEY STREET 21224 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 X Yes 2 □ No
If Yes, Give
Year or Dates: 1942-46 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. 8m 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) INSPECTOR 11 NATIONAL CAN CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM PLITT MARTHA GREEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is 1218 CARROLLTON LANE, BERLIN, MD. LINDA MATRICCIANI/NIECE 21811 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State BAYVIEW CREMATORY 11/29/04 | BALTIMORE, MARYLAND injury \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fund Service Licensee LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTO., MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final an Pnysician brand' Cerun disease or condition resulting in death) /Medical Due to lor as a consequence of): Examiner franchish list nor ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-transit resulting in death) Last Due to (or as a Box 68760. nding physician use as the buria Physician/Medical the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ been sig 1 Yes 2 No 3 Probably 4 Punknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 No 25. Was case referred medical 26. Place of Death Check onl one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 🗌 Yes 1 Inpatient 2 ER/Outpatient this 27. Manne Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. Certification: 1 atural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) W- C-1 4.0 2004 008358 e and address of person who completed cause of death (Item 23a) (Type, Print) HARTORD PATIZICIO to (1. 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Ma	ıryland	-	artment <i>tificate</i>			-	giene	0.1	0776	
	Physici	ian	1. Decedent's Name (First, Middle, Last,	oward	I	Prince				2. Date of De.	ath CU	20'04	2:30 a	a M
	/Medio		4a. Facility Name (If not institution, give					own, or Loca	ation of Death			nty of Death		
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	Funeral		5. Social Security Number 6. Set	7. Age	(In yrs. las		If Under 1	Year If U	Inder 24 Hrs. ours Min.	8. Date of Birt (Month, Da	th	9. Birth	place (State or F	-oreign
	Director		214-44-7779	M 2□F	58	Yrs.		,,,		May 14			land	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City I	Limits
	Mary f sh	tor	Maryland N/A		Ва	ltimo	re						1 Yes 2	. No
	r 28e	Director	10e. Street and Number				10f. Zip C	ode			10g. Citizen	of What Cou	ntry?	
	th with	ai D	1901 Breitwert A	venue			212	230			USA			
	items	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?		13.	Vas Deceder	nt of Hispan Cuban, Me	ic Origin? (Spe	cify Yes or No Rican, etc.)	- 14. F	Race - Ameri Black, White,		
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Oivorced	1 ☐ Yes 2 ☐ N If Yes, Give X	0		☐Yes 2		ecify:	,		city: Whi		
00	within 72 hours after death with the Maryland ane. then "naturel", or items 236 or 28e-f show the Medical Examana must be rediffed at	ed b	15. Decedent's Edu	Year or Dates:	-		lent's Usual (					Business/Ir		
15	in 72 n "na nedic	piet	(Specify only highest grad	e completed)	.)	(Give		done durina	most of worki	ng	TOD. KING O	Dusiness/ii	dustry	
212	d withi	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Tru	ck Dri	.ver		1	De	livery	r	
Maryland 21215-0036	be filed within 72 hours after death with the Marylar ital Hygiene. do other then "naturel", or items 23e or 28e-f show other, the Medical Examiner must be rediffed at	Be (	17. Father's Name (First, Middle, Last)					18. 1	Mother's Name	(First, Middle,	Maiden Surr	ame)		
yla		2	Joseph Howard		e, Sr				leanor_	Lorr			gadon	
Mar		100	19a. Informant's Name/Relationship (Ty						lumber or Rura					
	teall teall mm 2	Н	Bertha Windsor (Fi	ance	20b. Pla		I brel sition (Name		Avenue	ate Balt	20c. Locatio			
Baltimore,	S 40 10 0		1 ABurial 2 ☐ Cremation 3 ☐ F	Removal from State	cen	netery, cren	natory or othe	er place)	l I					
Ė	permit. Page Department of Importent: If any injury or once.		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licens</li></ul>	00_	Ceda		1 Ceme		11/30   Facility Lou		Brookl			
B	permit. Departn Importe any inju		11	23					Ave.,					
г	#		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused	the death.								Approximate Interval Between	en
	Physician		Immediate Cause (Final disease or condition	modes	tota	c 5.	mall	1011	100	Can	ـ. ما		Onset and Dea	
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	nce of):	· lact		1012	)			7	
· -	CAGITITIE		Sequentially list conditions,	Dua to /cc on							-			
	tad Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injuried exerts)	Due to (or as a	. conseque	nce or):								
	al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a	conseque	nce of):								
8760,	The law requires that the death certificate be executed the bas been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicail		d.										
9	tificat ng phy as th	Medi	IS SELVING											
Вох	eath certific attending p	an/\	23b. Was decedent pregnant	3c. If yes, outcome of			Ectopic preg	nancv				Date of deliv	,	
	at the dea by the at tached fo	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at 9☐Unknown			Other (spec					Month	Day Yea	ır
P.0	that the		Part II. Other significant conditions con	atributing to death bu	t not result	ing in the ur	derheing cau	se given in I	Part I	23e Did to	phacco use co	ontribute to t	he cause of deat	th?
Records,	signed be del	d by	, attin out of significant out o	Time and to down by	t not room.		idonying odd	so givoir iir i	arri.	18 <b>2</b> Y				
COL	w requir been si should	Completed								24a. Was			ppsy findings ava	allabla
Re	The lav	mc			,					autop		prior to co death?	mpletion of caus	se of
Vital		Ö	25. Was case referred to medical					26	Place of Death		-	1 🗆 Yes	2   No	
Ž.	ysic Is ce direc	To B	examiner? 1 ☐ Yes 2♥ No	fospital: 1  Inpatier	nt 2 EF		3 DOA	Othor	☐ Nursing Hon			Other (Specif	·γ)	
n of			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		8b. Time of Injury	280	. Injury at Work?	2	8d. Describe h	ow injury occ	urred		
Sio	Attending r death. ector: After by the fune	catio	2 Accident investigation				М	1 Tes						
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At hom . <i>(Specify)</i>	e, farm, str	eet, factory, o	office	2	28f. Location (S City or Tow	Street and Nui m, State)	mber or Rura	al Route Number	r.
	Hospitel 24 hours a Funerel I		29a. Certifier Certifying Phys	sician: To the best o	f my knowl	edne death	occurred at	the time da	te and place a	and due to the	Cause(s) and	mannar ac c	tated	
	To the Hospitel or within 24 hours afte To the Funerel Dis completely filled in	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner star	examinatio	n and/or inv	estigation, in	my opinion	, death occurre	ed at the time, o	date and plac	e, and due to	the cause(s)	
	To the within 2 To the complet	×	29b. Signature and title of certifier				29c. L	icense num	ber	1	29d. Date sig	ned (Month,	Day, Year)	
	1		Money	111			DE	352	S4		11/29	109		
	$\mu$		30. Name and address of person who co	ompleted cause of de	ath (Item 2			2 . 2		1 -				
	)		31. Date filed (Month, Day, Year)	MV 700	) Ca		1vo t	5 K) L	TIMOR	e M	1) 11	23	<del>}</del>	
`	Sta Registr	3	NOV 2 9 20	32. Registra	ı s əlgnatul		and a							
			**** G 3 CU	UT REPORT	Re L	r de	2010/							

DHMH 17 Rev 1/2001

	1 = For State Registrar	State o	f Marylan	-	artment of I		nd Mental Hy	ygiene 001	37723
Physician /Medical			atro				2. Date of D Month	Day V	3. Time of Death
Examiner	4 20 1014 84 244	institution, give street and nur	mber) HOSP-	- C	4b. City, Town, o	or Location o	f Death	4c. County of ANNE	Death ARINDEI
Funeral	5. Social Security Numb	er 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Date of B (Month, C 7 – 31 – 1		Birthplace (State or Foreign Country)
Director	212-16-955 Usual Residence of De		83	Yrs.			7-31-1	921	MD
Aarylan ed all		b.County Anne Arundel		y, Town or Lo n Burn					10d. Inside City Limits 1 ☐ Yes 2 X No
uter death with the Maryland rittems 23e or 28e-f show niner must be nutified at Funeral Director	10e. Street and Numbe				10f. Zip Code 2106	0		10g. Citizen of Wha	at Country?
<u> </u>	11. Marital Status 1 Never Married 3 Widowed 4	Armed Fo 1 Tyes If Yes, Giv	2. <b>ሺ</b> No ∕e	1	Vas Decedent of I f Yes, specify Cub		in? (Specify Yes or N Puerto Rican, etc.)		American Indian, White, etc. white
215-0036 thin 72 hours at the "natural; or the deal Exert	15.	Decedent's Education only highest grade completed)	ates:	16a. Deced	lent's Usual Occup	pation during most	of working	16b. Kind of Busin	
21215-00 21215-00 ed within 72 hot ygiene. in the Madrall Et. It is Madrall Et.	Elementary/Seconda		-4or 5+)		kind of work done DO NOT use retire of Educ	•	o. woming	Schoo1	System
aryland aryland should be lifected and Mental Hygin arrived other unmatic event.	17. Father's Name (Firs	t, Middle, Last) Sablowski					r's Name <i>(First, Middle</i> Leona Jab	e, Maiden Surname) lonski	
Mary and 2 sho	19a. Informant's Name	Relationship (Type, Print)  y Patro / son			g Address (Street B&A B1ve		ror <i>Rural R</i> oute Numi en Burnie	ber, City or Town, Sta MD 21060	ate, Zip Code)
Baltimore, Baltimore, Bernit. Pages 1 at Department of Hea mportent: If tem my injury or other	20a. Method of Disposi 1 X Burial 2 C	remation 3 Removal from	a.   C	emetery, cren	sition (Name of natory or other pla Veterans Cemete	<i>св)</i> 1	Date 1/30/04	20c. Location - Cit	
Balti Balti permit. Departir Importe any inju	21. Signature of Funer	al Service Lensee	M01364	22	. Name and Addre	ess of Facility	Singleton Glen Burn	n Funeral ie MD 2106	Home P.A.
Physician	23a. Part . Enter the c shock, or heart fa Immediate Cause (Fin- disease or condition	isease, or complications that collure. List only one cause on eal	aused the death ach line.		2/	-	FORME		Approximate Interval Between Onset and Death
/Medical Examiner	resulting in death)	Due to	or as a conseq	uence of):	ISORD	62			
(9 B sit	Sequentially list condit if any, leading to imme cause. Enter Underlyir Cause (Disease or inju that initiated events	ons, diate Due to (	or as a conseq						
Box 68760, death certilicate be executed e attending physician and drift ruse as the burial-transit clan/Medical Examiner	resulting in death) Last	c. Due to	or as a conseq	uence of):	SIDN				
Box 68's asth certificate at the certificate for use as the certificate state.		220 If was out	come of pregna	100/	7.3				
	23b. Was decedent pre in the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	1☐Live b	irth 2 Feta ant at time of d	Ideath 3	Ectopic pregnanc Other (specify)	у		23d. Date o Month	•
cords, P.O wrequires that the been signed by th should be detache	Faith. Diner significan	nt conditions contributing to de	eath but not res	ulting in the ur	nderlying cause gr	ven in Part I.		tobacco use contribu Yes 2 □ No 3[	ite to the cause of death?  Probably 4 Nichnown
() > 0 0								opsy prio dea	re autopsy findings available or to completion of cause of th?  Yes 2 No
of Vital Rec Physicien: The lav this certificate has all director, page 2	25. Was case referred examiner?	Hospital:	npatient 2	ER/Outpatien	Ott		of Death (Check only sing Home 5□ Res		(0
Vision of Attending Phy or death. rector: After this by the funeral d			of Injury th, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at rk?  Yes 2 \[ \] \	28d. Describe	how injury occurred	Specify)
Division of tell or Attending P is after death. Is Director: After ted in by the funers Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined 28e. Place building	of Injury - At ho ng, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location City or To	(Street and Number own, State)	or Rural Route Number,
he Hospi n 24 houn he Funer pletely fill	29a. Certifier 1 (Check only 2 one)		best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred at the ti restigation, in my o	me, date and opinion, deat	place, and due to the hoccurred at the time	, date and place, and	I due to the cause(s)
To t virbi	29b. Signature and title	of certifier		mD	29c. Licens		49	29d. Date signed (A No VEM 13E	
6	30. Name and address	of person the completed cause	e of death (Item	1 23a) (Type	Print) VIVE	Glen	burnie	mo	£ 25 2004 21061
State Registrar		A .	egistrar's Signa	iture	parks				

			For State Registrar	State of Marylar	nd / Depai	rtment of H	lealth and Death		ene2 () () (	37724
Age	Dhysisi	*	1. Decedent's Name (First, Middle, Last)	^				2. Oate of Death Month	Day Year	3. Time of Death
2	Physici /Medio	al	4a. Facility Name (If not institution, give s		+	4b. City, Town, or	Location of Dea	horomp	4c. County of Dea	M LC17 MOR
	Examir	er	SENTTY BU		THE	Dand	al(5 102	- N	Mary	lend Co
	Funeral		5. Social Security Number 6. Sex	N SINE	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day, Y		rthplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	81				June 3,1	91/ Phi	lippines
	lanylar show	Į.	10a. State 10b. County		ty, Town or Loca					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	r 28a-f	Director	MD Baltim  10e. Street and Number	ore	Owing	s Mills 10f. Zip Code		10g	. Citizen of What C	ountry?
	23a o 23a o ust be		9021 Amber Oaks	Way			1117			UNK
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Menlat Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show it item 27 is marked other than "natural", or items 20a or 28a-f show or other traumatic event, the Medical Examinat number colling and	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:	İ		spanic Origin? (9 n, Mexican, Puer Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	72 hou natura lical E	eted	A 15, Decedent's Educ (Specify only highest grade	ation	16a. Decede	nt's Usual Occupa	ation during most of wo	nduna 16	b. Kind of Business	
121	within	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. Do	ONOT us <i>e retired,</i> isewife	)	9	Own Ho	
d 2	i Hygie other	Be Co	17. Father's Name (First, Middle, Last)		пос	Isewile	18. Mother's Na	me (First, Middle, Mai		ome
ylar	should be ind Mental marked o umatic eve	To E	Higino Fabros					na Herero		
Maryland	d 2 sho th and ?7 is mu trauma		19a. Informant's Name/Relationship (Ty) Violeta Marantan	oe, Print) Daughter	91			ural Route Number, C Owings Mil		· · ·
	is 1 and 2 of Health item 27 i	117	20a. Method of Disposition	20b. F	Place of Disposi				c. Location - City or	
Baltimore,	Pages ment of ant: If it ury or o	100	1  Burial 2  Cremation 3  R  1  Other (Specify)	emoval from State	•	Cemetery	1	27/04 B	altimore,	, MD
Balt	permit. Pages 1 an Department of Heali important: If item 2 any injury or other <u>ance</u> .	1 10	21. Signature of Funeral Service Licenses	Can	E	Name and Addres	eral Hom	e Reiste	Reisterst rstown, M	
2			23a. Part1. Enter the disease, or complianock, or heart failure. List only on Imm. liate Cause (Final	e cause on each line.		19900	101			Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	ABDOM(NA) Due to (or as a conseq		C PONE	URYSM	WITUR	~	
	Examiner		Sequentially list conditions, b							
15	pet isit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	juence (II).					
	execu an and rial-tra	Exar	that initiated events cresulting in death) Last	Due to (or as a conseq	juence of):					
8760,	icate be executed physician and s the burial-transit	dlcal								
Box 6	eath certific attending p	0	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregna					23d. Date of del	livery
P.O. Bo	t the d by the ached	Physician/M	in the past 12 months?  1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Felta 4 ☐ Pregnant at time of d 9 ☐ Unknown		ctopic pregnancy Other (specify)			Month	Day Year
S,	ires tha signed l d be det	ρ	Part II. Other significant conditions con	tributing to death but not res	ulting in the und	erlying cause give	n in Part I.	23e. Did tobac		othe cause of death?
Records,	w requir been si should	letec						24a. Was an		
Re	The lav	Completed						autopsy performed	d?// death?	utopsy findings available completion of cause of 2 \( \square\$\) No
		Bec	25. Was case referred to medical examiner?					ath (Check only one)	10 12 13	20110
0	tlending Physicien: The leath. tor: After this certificate ha the funeral director, page	- To	1 Yes 2 No		ER/Outpatient 28b. Time of		4 🗀 i tui sii ig i	forme 5 Residence		cify)
0	inding ath. r: Afte	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Work' M 1 □ Y	? ′es 2 □ No		njary socialis	
Division of	or Al	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stree	it, factory, office		28f. Location (Stree City or Town, S		ıral Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical (	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my known:  On the basis of examina and manner stated.	wledge, death o tion and/or inve	occurred at the time stigation, in my opi	e, date and place inion, death occu	a, and due to the cause urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month	h, Day, Year)
	1		My 1	NO			5643	0 NOI	render 2	12004
	- 1		30. ame and address of cerss, who con	mpleted cause of death (Iten	n 23a) (Type, Pr	int)	Ast I	Roydal	15/000	-MD
	Sta	5	31. Date filed (Month, Day, Year)	32. Registrar's Signa	15	1			131011	, , , , , , , , , , , , , , , , , , , ,
	Registr	ar	NOV 3 0 2	MA Denser	a y	Anne	1/2/			

DHMH 17 Rev 1/2001

Amend item#22, periff, G837, II/30/04 TI State of Maryland / Department of Health and Mental Hygiene OL 1 - For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death NOVEMBER **Physician** 12033 10:15AM JANIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NORTHWEST HOSPITAL Randalistown

If Under 1 Year If Under 24 Hrs. 8. BALTIMORE 5. Social Security Number Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 179.20.3124 1 ☐ M 2 🕱 F 80 Yrs. SC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Te Medical Example Indifficit at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Baltimore 1 TXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 US.A. 3706 Gelston Drive Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BEAUTICIAN SELF-EMPLOYED 9th grade NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ullian Lightle Charles Demison P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Pity or Town, State, Zip Code) Bultimore, MD 21229 Lerenzo Ross Husband 3704 Guston Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 12.02.04 Randalstown, MD PARK KING 4 □ Donation 5 □ Other (Specify) 21. Signat e of Funeral Service License 22. Name and Address of Facility Vaughn C. Greene Funeral Services 5151 Baltimore Nat'1 Pike Baltimore au 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medicai the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy atter for u Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 1 🗌 Yes 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes the Hospitel or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending after death. Diractor: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide o Funaral Die Funaral Die Funaral Dietely filled is 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 290 Date signed (Month, Day, Year) 29b. Signature and title of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address IMPORKIAZ 3 NWHE 32. Registrar's Signature 31. Date filed (Month Day, Year) State

Registrar

NOV3 0

	1 - For State Registrer	State of Maryland / Department of Health and Maryland / Certificate of Death	Mental Hygiene 004 37726
Physician	1. Decedent's Name (First, Middle, Last	)	2. Date of Death  Day  Yeer  O 2/1 O H
/Medical Examiner	4a. Facility Name (If not institution, give	Street and number)  Ab. City, Town, or Location of Death	4c. County of Death
Funeral	5. Social Security Number 6. Se		8. Date of Birth (Month, Day, Year)  9. Birthplace (State or Foreign Country)
Director	29-32-4009 15 Usual Residence of Decedent	M 201 F 79 Yrs. Months Days Hours Min.	(Month, Day, Year)  D3 c9 1925  Country)  NC
aryland show	10a. State 10b. County	10c. City, Town or Location  BALTIMORE	10d. Inside City Limits 1 ☑Yes 2 ☐ No
with the Mar s or 28e-f si be notified	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
death with the Maryland ms 23e or 28e-f show triust be notified at		12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	Decify Yes or No-
036 Urs after Latin or the	3 ☑Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:  If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:	Rican, etc.)  Black, White, etc.  Specify: BLACK
21215-0036 ed within 72 hours all ygiene. Per then "netural", or ser then "netural", or it. Its Mudical Exam	15. Decedent's Edt (Specify only highest grad	ucation 16a. Decedent's Usual Occupation (Give kind of work done during most of work fife, DO NOT use retired)	
C212 T212 ed withi ygiene.	Elementary/Secondary (0-12)	N/A DAYCARE PROVIDE	· · · · · · · · · · · · · · · · · · ·
Vland Vland be fill Wental H arked out	17. Father's Navle (First, Middle, Last) PETE WATERS	18. Mother's Nam	e (First, Middle, Maiden Sumame)  PAUARD
Mary Mary 42 sho th and N 7 is ma treums	19a. Informant's Name/Relationship (T	196, Print) 19b. Mailing Address (Street and Number or Ru 3/Daughter TID BRUNE STREET	ral Route Number, City or Town, State, Zip Code)  BAUTIMORE MD 21201
Baltimore, M Permit. Pages 1 and: Department of Health Importent: If tiem 27 Importent: If tiem 27 Importent: If tiem 27 Importent: If tiem 27 Importent: If tiem 27	20a. Method of Disposition  1 ⊠Burial 2 □ Cremation 3 □	20b. Place of Disposition (Name of	Date 20c. Location - City or Town, Slate
altimore, altimore partient Pages 1 a partient of the portent: if it is portent: if it is y injury or other	4 □ Donation 5 □ Other (Specify, 21. Signal e of Funeral Service Licens	GARRISON FOREST 11210	7 OH DWINGSMILLS, MD L FUNERAL SERVICES
Bal permi Depar Impor any ir	Daugh C.	SISI BALTIMORE NA	T'LPIKE BALTO, MD 21229
Physician	23a. Part 1. Enter We disease, or comp shock, or heart failure. List only o immediate Cause (Final disease or condition	lications that caused the death. Do not enter the mode of dying, such as cardiac ne cause on each line.	or respiratory arrest, Approximate Interval Between Onset and Death
/Medical Examiner	resulting in death)	Due lo (or as a consequence of):	2
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	
60, be executed sician and burial-transit all Examiner	resulling in death) Last	c.  Due to (or as a consequence of):	
68760, ilicate be ex g physician as the burial edical Expense	(	d	
P.O. Box 68 nat the death certifics d by the attending pt letached for use as t Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery  Month Day Year
that the de ed by the detached	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	On Pidale and Advantage
cords, F wrequires tha been signed is should be det	Dicholes L	ntributing to death but not resulting in the underlying cause given in Part I.    Perten Sion	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
0 8 8 0		1	24a. Was an autopsy autopsy lindings available prior to completion of cause of death?  1   Yes 2   No 1   Yes 2   No
of Vital F Physician: Th Physician: Th this certificate ral director, pag	25. Was case referred to medical examiner?	Hospital:	h (Check only one)
on of Valing Phys.  After this of funeral dir.	T Tes 20 No	28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)  28c. Injury at Work?	ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred
Division of Vital Re To the Hospitel or Attanding Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	2 Accident investigation 3 Suicide 6 Could not be determined	M 1 Yes 2 No	281. Location (Street and Number or Rural Route Number,
Div pitel or purs afte erel Dir filled in l			City or Town, State)
Divisio  To the Hospitel or Attandi within 24 hours after death. To the Funeral Director. A completely filled in by the tr		sicien: To the best of my knowledge, death occurred at the time, date and place, iner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	red at the time, date and place, and due to the cause(s)
To the within To the common N	29b. Signature and title of certifier	29c. License number 8953	5 November 24, 2004
3	30. Name, and address bl person who c	ompleted cause of death (Item 23a) (Type, Print) M. D. C/O Mary land Geneva	1 Hospital
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	,

DHMH 17 Rev 1/2001

UNK 04-376

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

27State of Maryland / Department of Health and Mental Hygiene

Reg. No:	0	0	1	2	7
Reg. No:	U	U	r.	J	- [

0	4-7489	Unpend Item 23a,27,28a-1 per me (638a)	icate of Death	Reg. No.	04 37727
	Physician	Decedent's Name (First, Middle, Last)		2. Dete of Deeth Month Dey	3. Time of Death
4	/Medica	Mario Medina Reyes		NOVEMBER 21,	2004 7:43a
	Examine	4a Facility Name (If not institution, give street end number) 1800 GOUGH STREET	4b. City, Town, or Local BALTIMOR		ty of Deeth
9	Funeral			8. Date of Birth (Month, Day, Year)	I / A  9. Birthplace (State or Foreign
700	Director		onths Days Hours Min.	(Month, Day, Year) May 10,1980	Birthplace (State or Foreign Country)     Mexico
	enyland show	10a. State 10b. County 10c. City, Town or Location	on		10d. Inside City Limits
	r 28a-f sho	unknown unknown unknown			1 0 465 2 0 No
	ith the	10e. Street end Number	Of, Zip Code	10g. Citizen of	What Country?
	ath w	unknown	unknown	Mex	
_	offer death with the Me or flems 23a or 28a-fs direct must be notified Finansi Director	11. Marital Status 12. Was Decedent Ever in U,S. 13. Was Hyde Armed Forces? 1 □ Yes 2,□ No	Decedent of Hispanic Origin? (Spe s, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	ace - American Indian, ack, White, etc.
Maryland 21215-0020	72 hours efter death with the Meryland natural", or items 23s or 28s-f show dical Examiner must be notified at short hy Europea Director	1 Never Married 2 Married 1	Yes 2□No Specify: Mex	ican Speci	White
5-0	be filed within 72 hours etal Hygiene. d other than "natural", o	15. Decedent's Education 16a. Decedent (Specify only highest grade completed) (Give kind	s Usual Occupation of work done during most of working NOT use retired)		Business/Industry
121	E 2	Elementary/Secondary (0-12) College (1-4or 5+)			
2	d 2 should be filed with the and Mental Hygiene. The marked other ther traumatic event, the To Re Comm	3 Bag 17. Father's Name (First, Middle, Last)	ger	(First, Middle, Maiden Suma	ocery
an	nould be in Mental in Mental or marked or mark			,	ine)
ary	2 shoul end M la mark raumati	Adeitho Medina	Unknowi ddress (Street and Number or Rure)	n Reyes I Route Number, City or Towr	n, Stete, Zip Code)
Z,	F 97 64 4	Marco Reyes 244 Wa	shington Stree	et Baltimor	e MD 21231
ore	of Hea of Hea of Item ?	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State	n (Name of ry or other place)	Date 20c. Location	- City or Town, State
Baltimore,	Pag ment ment: Pag jury o	4 Donation 5 Other (Specify) unknown		unk	nown
Bal	permit. Pages i Depertment of t Important: If ite any Injury or of once.	Cha	me and Address of Facility rles S. Zeile:	e e com Tm	23
_		23a. Part 1. Enri the disease, or complications that caused the death. Do not enter the shock, an eart failure. List only one cause on each line.	4 Fastern Aver	ue Baltim	ore. MD 21224
	Dharistan	23a. Part : Entyr the disease, or complications that caused the death. Do not enter the shock, wheart failure. List only one cause on each line.	e mode of dying, such as cardiac or	respiratory arrest,	Interval Between Onset and Death
4	Physician / /Medical	Immediate Cause (Final disease or condition Acute alcohol intox:	ication		
, it	Examiner	resulting in death)  Due to (or as a consequent			1
	Pa iii	<b>a</b> h			
	ficate be executed physician end ts the bunal-transit edical Examiner	Sequentially list conditions, if eny, leading to immediate	ce of):		
68760,	sician buria	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence or injury that initiated events  Due to (or as a consequence or injury that initiated events)			
89	certificate be execuing physician and use as the burial-tran	resulting in death) Last	ce of):		
Box	eath certi attending I for use a				
	0 0 0	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23b. Did tobacco use co	ontribute to the cause of death?
P.0	The law requires that the sate been signed by the page 2 should be detechend.			1 ☐ Yes 2 ☐ No	3 Probably 4 Unknown
ds,	The law requires the cate has been signed, page 2 should be completed by			24a. Was an autopsy	24b. Were autopsy findings
χō	v require			performed?	available prior to completion of cause
Re	he lave hes age 2			XYes 2LING	of death?  1/2 Yes 2□ No
of Vital Records,		25. Was case referred to medical	26. Place of Death		20165
) t	Physician: this certific ral director,	examiner?  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4☐ Nursing Hom	e 5□ Residence 6 XiOth	her (Specify)SCENE
n o	ing Ph After th uneral	27. Menner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Dey Year) Injury 1 Injury	Work?	8d. Describe how injury occur	rred <b>unk</b>
Division	Attending or death.  actor: After by the fune	3 Suicide 6  Could not be 11-21-04	A 1 ☐ Yes 2 X No	Rf Location (Street and Num	har or Pural Pouto Number
Ρį	tal or Attending P rs efter death. al Director: After t ed in by the funers Certification:	4 Homicide determined splitting, etc. (Specify)  Street		Bf. Location (Street and Number City or Town, Stete) 18 Baltimore, MD	00 blk. Gough S
	hou hou liner ly fill	29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occ	urred at the time, date end place, ar	nd due to the cause(s) and m	anner es steted. and due to the cause(s)
	within 24 To the Fe complete	one) and manner stated.  29b. Signature and title of certifier/	29c. License number		ed (Month, Day, Yeer)
	F3F8	1 1 / Ble a UNO	OCME		ER 22, 2004
	181	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print	)		
200	10	10.	EET, BALTIMORE,	MARYLAND 212	201
18	State	31. Dete filed (Month, Day, Year) 32 Registrer's Signature			
P.11	Registrar	NOV 3 0 2004			
υH	MH 16 Rev 6/95				

		í	For State Registrar	State of Marylan	-	rtment of H tificate of L		ental Hygie	2004	37728
	Physici		1. Decedent's Name (First, Middle, Last) Potricia			Rosenh	0.00.00	2. Date of Death Month	Day Year	A Property and the same of the
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give s  John S Hopk  5. Social Security Number  16. Sex	1/	last birthday) Yrs.	4b. City, Town, or PCC 1 If Under 1 Year Months Days	Location of Death  WOLL  If Under 24 Hrs.  Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Dec N/A	
	τ		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Loc	ation		0011 15,	1540   11	10d. Inside City Limits
	e-f sho	ctor	Maryland Anne Aru	nde1	Sev	ern				1 ☐ Yes 2 🛣 No
	with the	Dire	10e. Street and Number 1876 Cedar Drive			10f. Zip Code	L144	10g.	Citizen of What C	Country?
36	be filed within 72 hours after death with the Maryland ttal Hygiene.  Id other than "naturel", or Items 23e or 28e-f show event, the Medical Eracinal matter colling at	by Funeral Director		2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give	· ·		spanic Origin? (Spen, Mexican, Puerto I	city Yes or No- Rican, etc.)	14. Race - Am Black, Wh	ite, etc.
2-00	72 hour		15. Decedent's Educ (Specify only highest grade		16a. Decede	ent's Usual Occupa	ition luring most of workii	168	o. Kind of Busines	White s/Industry
121	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	ing Hoste	)	,g	Vending	Machine
Maryland 21215-0036	be filed within tal Hygiene. d other then	Be Co	17. Father's Name (First, Middle, Last)		Vend	Ing noble	18. Mother's Name	(First, Middle, Mail	den Sumame)	TRICITIE
ryla	should by the marked marked	To	Frank Wiggington  19a. Informant's Name/Relationship (Type	e. Print)	19b. Mailing	Address (Street a	Margare	et Carter		Zin Code)
	nd 2 state at 27 is r treu		Albert D. Rosenber	ger/husband	1876	Cedar Dri	ive Sever	m, MD 21	144	
nore	M O		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re	moual from State	emetery, crem	ition (Name of atory or other place matory			Baltimo	
Baltimore,	permit. Page Department Important: II any injury or once.		' 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Lipense				saf Facility (			re, m
8	90E # 9		Thomas Grego 23a. Part1. Enter the disease, or complice		2	99 Freder	rick Road	Baltimo	re, MD 2	1228 Approximate
	Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Backeric  Due to (or as a consequence)			,, 000.1 00 00.0100 0	. roopilatery arroot,		Interval Between Onset and Death 3 WECKS
ı	Examiner	_	Sequentially list conditions, b.	Acute Resal	Faire	re				3 weeks
	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter of deriving Cause (Disease or injury that initiated events	Altered Men	1 1 6 1	atus				3 weeks
68760,	icate be executed physicien and s the burial-transit	edical Exa	resulting in death) Last	Orthotopic		+ Trans	plant			Syears
P.O. Box 6	death certif e attending id for use a	Physician/Me	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	ic. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	blivery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions conf	ributing to death but not resu	ulting in the und	derlying cause give	n in Part I.			o the cause of death?
Vital Records,	The ate h page	Completed			-			24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of s
Vite	Physicien: The this certificate har ral director, page	To Be	25. Was case referred to medical examiner?  1 ☐ Yes ②X No	ospital: 1 1 1 1 1 2 1	ER/Outpatient	3□ DOA Othe	26. Place of Death	(Check only one) ne 5 ☐ Residence	6 DOther /Sne	aciful
sion of	ding Ph h. After th funeral		27. Manner of Death 1 ★Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		8d. Describe how in		sury)
Division	P in C	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	et, factory, office	2	8f. Location (Street City or Town, St		ural Route Number,
	To the Hospitel of within 24 hours a To the Funerel Completely filled in	Medical	29a. Certifier 1 Certifying Phys (Check only one)	cian: To the best of my knower: On the basis of examination and manner stated.	wledge, death tion and/or inve	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	nd due to the cause od at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	Λ.0		29c. License		29d.	Date signed (Mon	th, Day, Year)
•	10		30. Name and address of person who con	blez MD	23a) (Type B	RES-	000	Nov	ember	23,2004
	Ψ						imare N	10. 2128	7	
	Sta Registr	-	31. Date filed (Month, Day, Year) NOV 3 0 200	32. Registrar's Signal	ture	Spark.				

Physicia /Medic Examine

Funeral Director

	1 - For State Registrar	State of Marylan	_	artment of F		_	giene	004	37729
	Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
n al		ard Reighard				Novemb	er 2	2 200	<del></del>
ŗ	4a. Facility Name (If not institution, give s			4b. City, Town, o.			4c. 0	County of Dea	th
	Sinai Hospital  5. Social Security Number 6. Sex	of Baltimor		Baltimo If Under 1 Year	If Under 24 I	Hrs. 8 Date of Bird	th	O Rie	thplace (State or Foreig
	194-40-85 / / Usual Residence of Decedent	XM 2□F 53	Yrs.	Months Days	Hours A	JUNE 2	, Year 9	51 Pe	nnsylvania
7	Maryland N/A	10c. Cit	y, Town or Lo		_				10d. Inside City Limits
ecto	Maryland N/A  10e. Street and Number			Baltimor	e		10a Citiz	en of What Co	1 TYes 2 □ No
Completed by Funeral Director	1723 Poplar Road	1		101. 2ip Code	21216		rog. Citiz	US	
nera	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of H	ispanic Origin	? (Specify Yes or No uerto Rican, etc.)	- 1	4. Race - Ame Black, Whit	
y Fu	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give	1	1 Tes 2 No	Specify:	dorto i licari, etc.)			White
Q p	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's Educ	Year or Dates:	162 Dece	dent's Usual Occup	ation			d of Business	Andustra
piet	(Specify only highest grade	e completed)	(Give	kind of work done of DO NOT use retired	during most of	working	TOD. KIN	a or business	industry
mo:	Elementary/Secondary (0-12)	College (1-4or 5+)	Nev	ver Worke	d			N/A	
o Be C	17. Father's Name (First, Middle, Last)	_				Name (First, Middle,	Maiden S	Surname)	
0	Raymond R. Reigh					n M. Rhoad			
	19a. Informant's Name/Relationship (Ty) Ellen Gerber/siste					r Aural Aoute Numbe ndalk, MD	-		Zip Code)
	20a. Method of Disposition		_	esition (Name of matory or other place		Date Date		ation - City or	Town, State
	1 ☐ Burial 2 X Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)	iernovai ironi State		matory or other place ematory,		/26/04		Raltin	more, MD
	21. Signature of Funeral Service License					of Maryl	and		note, ND
	Thomas Gregor	reger	29	99 Freder	ick Roa	d Baltim	ore.	MD 212	228
	23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the deati							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	Septic S	hock						10 days
	resulting in dealth)	Due to (or as a conseq	uence of):		to one wood				
er	Sequentially list conditions, but any, leading to immediate	Endocard Due to for as a nonseq	neuse of).	gram p	ositive	cocci)			10 days
m	cause. Enter Underlying Cause (Disease or injury that initiated events	Chronic N	la receto	Im (Int	Yavensz	is dru a	buse	V	2 veas
Exa	resulting in death) Last	Due to (or as a consequence	uence of):			J			7
Ca		j.							
Med	IF FEMALE:	3c. If yes, outcome of pregna	I DOW						
Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3□	Ectopic pregnancy Other (specify)			23	3d. Date of del Month	Day Year
Jysi	1 Yes 2 No 9 Unknown	9□ Unknown							
	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause grv	en in Part I.	23e. Did to	bacco us	e contribute to	the cause of death?
led						_ 1_Y	′es 2□	lNo 3∏Pr	obably 4 Minknown
ple						24a. Was	sy	prior to o	topsy findings available
Completed by							med? 2 No	death?	2010
Be	25. Was case referred to medical examiner?	lospital:		Oth	00	Death (Check only o			
. To	1 ☐ Yes 2 ☐ No	28a. Date of Injury	ER/Outpatien	it 3 DOA	4 Li Nursin	g Home 5 Resid			cify)
atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □ No				
iffica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specific	ome, farm, str	eet, factory, office		28f. Location (S City or Tow		Number or Ru	ıral Route Number,
Cer		Dundang, old. (Oppon)	·/			0.0, 0.7			
Medical Certification:	29a. Certifier 1 Certifying Physical Check only 2 Medical Exeminates	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	h occurred at the tin vestigation, in my o	ne, date and pl pinion, death o	ace, and due to the occurred at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)
Me	29b. Signature and title of certifier			29c. License	e number		29d. Date	signed (Monti	h, Day, Year)
	Rachel Harts	man M.D.		REC.	-000	^	Joven	ber 2	2,2004
	30. Name and address of person who co	mpleted cause of death (Item	1 23a) (Type,		£ _				1
	Rachel Hartman,		i Ho	spital o	F Balt	more			
e	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ilure /	5 Soa	Kal				

DHMH 17 Rev 1/2001

Stat Registra

State of Maryland / Department of Health and Mental Hygiene State Registre MEND ITEM #20b PER FH G837 10 480 124 e JH Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2118 M PHYLLIS ESTELLE RODGERS 2001 NOV. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Union Memorial Hospital Baltimore City N/A5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1□M 2₩F Hours 88 Director 215-09-8414 1916 Maryland Usual Residence of Decedent death with the Maryland 10a State 10b. County iral, or itama 23a or 28a-f ehow Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Maryland N/ABaltimore City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 606 E. Gittings Avenue 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter or and of Health and Mental Hygiene. In and 17 is marked other than "natural, or iter and 17 is tranked other than "natural, or iter and 17 is tranked other than and 17 is a Medical Estatina I ary or other traumatic event, tre Medical Estatina I ary or other traumatic event, tre Medical Estatina 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No þ Specify 3 Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Dept of Health State of Maryland College (1-4or 5+) Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fillmore Webster Rodgers 2 Frances Agnes Michalski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie T. Christian (Cousin) 7740 Outing Avenue, Pasadena, Maryland 21122 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of H Important: If Ite eny injury or ot once. 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LOUDON, PARK CFMETTERY 11/29/2004 Baltimore, Maryland 21. Signiture of Funeral Service Upens Martin D. Laws 22. Name and Address of Facility woon Mitchell-Wiedefeld Funeral Home, Inc. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Maryland 21212

proximate Interval Between Onset and Death Immediate Cause (Final Pulmonar Physician EMBOWdisease or condition resulting in death) /Medical Due to (or all a consequence of): Examiner Sequentially list conditions, 1 a.y, labourg to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 □Ectopic pregnancy ō Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à page 2 should be UBSTYNGTIVE pulmonary distast 1 Yes 2 No 3 Probably 4 Unknown UlcerATIVE (ULITI 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certilicate has autopsy performed? 1 Yes 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) funeral dir Certification: To 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Alter Hospital or Attending 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) LOULLY n MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ruan Bayimore 104 TUNBRIDGE M.D. 31. Date filed (Month, Da Registrar Signatur State Registrar

		1	For State Registrar	State of Maryla			of Health			giene Rog. No.	004	37731	
Ì	Physicia	an	1. Decedent's Name (First, Middle, Las  Dorothea R						Date of De Month		Year 2004	3. Time of Death 2235 M	
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give University of Ma 5. Social Security Number 6. S.	street and number) - Uland Medica	i. last birtnday)	Bottler 1	own, or Location    Company   Maring   Hours	on of Death  Ore  ler 24 Hrs. 8.	Date of Bir (Month, Da	4c. (	N/A 9. Birtl	nplace (State or Foreign	7
	aryland show dat		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo							10d. Inside City Limits	
	ath with the Marylar 23a or 28a-f show	Director	MD N/A  10e. Street and Number		Baltin	10f. Zip C				10g. Citiz	en of What Co		
	e E	Funeral D	1111 N. Calho 11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decede	ant of Hispanic (by Cuban, Mexic	Origin? (Specify can, Puerto Ric	/ Yes or No	- 1	4. Race - Ame Black, White		_
5-0036	ours after rrai', or ite	by	1 ☑Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ Ho If Yes, Give Year or Dates:		1□Yes 2	TNo Speci				Specify: 3	lack	
1215-(	within 72 hours after ene. than "natural", or Ite re Medical Executor	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give	DO NOT use	done during m	ost of working		16b. Kir	Bar	ŕ	
and 2	be filed ntal Hygi od other event, I	Be	17. Father's Name (First, Middle, Last)		.l.	Dur	18. Mo	other's Name (F			Sumame)		_
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	To	19a. informant's Name/Relationship (	Type, Print)			Street and Nun	mber or Rural R	oute Numb	er, City or	Town, State, 2		
altimore, N	0 0 = =		Novella Robin  20a. Method of Disposition  1 Description  1 Descri	Removal from State	Place of Dispo	sition (Name	e of her place)	Dec. 2	•	20c. Loc	cation - City or		7
Baltin	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Licer		22	2. Name and Hari	Address of Fa	e Fune	eal Soldin	שתויל	e, PrAn ZIZOT	1925	
0,	Physician /Medical Examiner  penusy p	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Endocar Due to (or as a const  c. Intravent Due to (or as a const  c. Intravent Due to (or as a const	ath. Do not ent  yy En  equence of):  ditis  equence of):	er the mode	of dying, such					Approximate Interval Between Onset and Death 2 days  / week	
.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 I≥ Onknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	tal death 3	⊒Ectopic pre ⊒ Other (spe					3d. Date of del Month	Day Year	
ds, P	uires that signed t ld be det	by	Part II. Other significant conditions of End Stage Yea		esulting in the u	inderlying ca	iuse given in Pa	art I.	23e. Did			the cause of death? obably 4 \( \subseteq Unknown	1
Record	hyaician: The law requir his certificate has been si I director, page 2 should	Completed							24a. Was auto perfo		24b. Were au prior to death?	topsy findings available completion of cause of	€
Vital	Phyaician: ' r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:			Other	ace of Death (C					_
of	ng P	tion: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Bc. Injury at Work?		5 🗌 Resi			city)	
Division	To the Hoapital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	De 280 Piaco of Injuny - At		reet, factory,	, office	28f		Street and wn. State,		ıral Route Number,	
	Hoapita     24 hours     Funeral     etely filled	Medical C	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa	hysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, deat	th occurred anvestigation,	at the time, date in my opinion,	and place, and death occurred	d due to the at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier	440			License numb				e signed (Mont		
)	Ż		30. Name and address of person who	completed cause of death "	lom 22a) /Tues	Print)	1850	48		No	N 26	2004	
	1		Richard Eric	cson, MD	22 50	outh C	areen s	Se; Bal	timoi	re, 1	MD; 3	21201	
	St Regist	ate rar	31. Date filed (Month, Day, Year) NOV 29 2		nature	corte		,		,	,		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 27, 2004 **Physician** ROSE MILDRED ROSKES 9:25 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RUXTON PIKESVILLE NURSING HOME PIKESVILLE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day APR. 2, 1914 **Funeral**  Birthplace (State or Foreign Country) Months 1□M 2**∏**F 90 Director 212-01-4564 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "naturel", or items 23a or 28e-f show r traumatic event, the Medical Examitm: mast be notified at 10d. Inside City Limits Director MD 1 ☐ Yes 2 🏋 No BALTIMORE PIKESVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 SUDBROOK LANE 21208 Be Completed by Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2XNo 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: WHITE Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene, other than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) rmit. Pages 1 and 2 should be fili ppartment of Health and Menfal Hy portant: If item 27 Is marked oth y injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Sumame) ALLIKER **EPHRAIM** HILDA SUTTLEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 CLIFFDWELLER COURT - OWINGS MILLS, MD 21117 SAUL ROSKES / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 1 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CEMETERY 11/28/2004 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses Mevare cusu 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Physiclan/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Àq 4 Unknown 1 🗌 Yes 2 🙀 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 Yes 2 X No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Thomicide filled in within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D16632 NOVEMBER 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAUL ROSKES, M.D. 8 CLIFFDWELLER COURT - OWINGS MILLS, MD 21117 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 3 0 2004 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

Amend item#1, perMD, G838, 12/28/04 TT

State of Maryland / Department of Health and Mental Hygiene O O I

			For State Registrar	State of Marytain		rtificate of				leg. No.	3//33
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Judy Anne Rea	rdon	<b>D</b>			2	2. Date of Dea Month	Day Yea	
	/Medic Examin	al	4a. Facility Name (If not institution, give st	reet and number)	Rear	4b. City, Town, o	r Location	of Death	NOV. 2	26, 2004 4c. County of De	12:40p <sup>M</sup>
	CAdmin	CI	Holy Cross Hos			Sil	ver	Spri	ng	Montgo	
	Funeral Director		210 10 1/1/	7. Age (In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	B. Date of Birth (Month, Day 6/22/	9. E 1944 Ba	Sinthplace (State or Foreign Country)  1timore, MD
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside City Limits
	Mary a-f sh	tor	MD Montgome	ry Si	lver	Spring					1 ☐ Yes 2 🔀 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "natural", or Items 23e or 28e-f show any injury or other traumatic event, The Medical Examinational be notified at once.	Funeral Director	10e. Street and Number 2208 Colston Dr	ive #203		10f. Zip Code 2091	0		1	10g. Citizen of What USA	· ·
	ems 2	iner	11. Marital Status	2. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of H	lispanic Or an, Mexica	igin? (Speci n, Puerto Ri	ify Yes or No-	14. Race - Ar Black, W	merican Indian, hite, etc.
200	ours afte	by	1 Never Married 2 Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:			Specify:	White
<u>ה</u>	"natu	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	oation during mos	st of working	7	16b. Kind of Busines	ss/Industry
7	within iene. r then	ошо	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +		iter/Ed				U.S.Gov	vernment
2	be filed Ital Hyg Ital other	BeC	17. Father's Name (First, Middle, Last)			,	18. Moth			Maiden Surname)	02111110110
ya	rould b	10 E	James Reardon					ra Jo	-		
Na	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Type Mary Reardon/Si								a. Zip Code) 20910
บ์	Healt tem 2		20a. Method of Disposition			sition (Name of matory or other place		Da Da		20c. Location - City	Spring, Md or Town, State
Ē	Pages ment of ant: If it ury or o		1 ☐ Burial 2 【Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)			ake Cre		1/29	/04 H	Beltsvil	le,Md
Dallimo	permit. Departm Importa any inju		21. Signature of Funeral Service License	5-	PH	Name and Addre	RÍNA	LDI I	FUNERA	AL SERVI	
			23a. Part1. Enter the disease, or complice shock, or he in failure. List only one	ations that caused the deati	h. Do not ent	er the mode of dyir	ng, such as	cardiac or	respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Melasto	tre 1	Von	ma 6	161	VLa	Cense	Onset and Death
	/Medical Examiner		resulting in dealh)	Due to (or as a consequent	uence of):			-	1	7	1 yes
	Lxammer	70	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):					-	-
_	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
S C	an and		resulting in death) Last	Due to (or as a consequence	uence of):						
09/90	rtificate be executed ng physician and as the burial-transit	Aedicai	d.								-
OX O		/Me	IF FEMALE: 23	ic. If yes, outcome of pregna	ancy					23d. Date of o	delivery
O. BO	ne death cert the attendin	Physician/N	23b. Was decedent pregnant in the past 12 pronths?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)	у			Month	Day Year
ŗ	law requires that the de as been signed by the: 2 should be detached		Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	nderlying cause gru	en in Part	1.	23e. Did to	bacco use contribute	lo the cause of death?
S	quires in sign	ed by							1 □ Y	es 2□No 32	Probably 4 DUnknown
ecord	aw ren as bee 2 sho	Completed							24a. Was a	an 24b. Were	autopsy findings available to completion of cause of
Ľ	The ate has page	Com							perfor	med? death	?
VITA	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		oth	200		Check only or		
ō	Phys r this ral dii	: To	1 ☐ Yes 2 No	28a. ate of Injury (Month, Day Year)	ER/Outpatier 28b. Time o	IL 3 DOX	4 🗀 14	_		ence 6 Other (S) ow injury occurred	pecify)
0	Attending I ir death. ector: After by the funer	atior	1 Platural 5 ☐ Pending 2 Accident investigation	(Month, Day Year)	Injury		rk?  Yes 2. ☐	]No			
UIVISION	i Sir de	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, sti y)	reet, factory, office		28	If. Location (S City or Tow		Rural Route Number,
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical C	29a. Certifier Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my o	me, date ai opinion, dea	nd place, an ath occurred	d due to the c	ause(s) and manner late and place, and d	as stated. lue to the cause(s)
	To the To the compl	Me	29b. Signature and title of certifier	-11		29c. Licens		777		29d. Date signed (Mo	onth, Day, Year)
	)		1	ill		D	76	233	1	11.27	04
	18		30. Name and address of person who cor							•	
	Sta	ate	S.K.Gupta MD 31. Date filed (Mont) 20	1300 Fore	ALUIO A	en Rd.	Silv	er S	pring,	Md	
	_ Jic		44049 0 50	U4 Beneria	- A	A	40 1				

Description   Care				For State Registrar	State of	Marylan	d / Depa <i>Cei</i>	artment of H	ealth a Death	and Me	ental Hyg	iena og No.	004	3773	4
Truntal Director  Fundal Section (Control Plance and Authorities)  Fundal Section (Con	I				,						Month	Day		3. Time of Death	
Social Security Numbers  215-12-21-29  178 W 2 F 7 Reg (fly yrs is set primary).					-			-					,		
Value   Valu							lact hirthday)				9 Date of Birth				ian
Top   State   Top   Document	L			215-12-5129						Min.	May 26	,1920	Ma	aryland	
Edward  J. Roberts  Florence  Harker  19a. Informant's NamelRelationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Mr. N. Craig Cutter – Nephew  20a. Membrod of Disposition  12b Busial 2   Clemation 3   Removal from State  12b Busial 2   Clemation 3   Removal fro		ow ow				10c. Cit	y, Town or Lo	cation				· · · · · · · · · · · · · · · · · · ·		10d. Inside City Lim	iits
Edward  J. Roberts  Florence  Harker  19a. Informant's NamelRelationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Mr. N. Craig Cutter – Nephew  20a. Membrod of Disposition  12b Busial 2   Clemation 3   Removal from State  12b Busial 2   Clemation 3   Removal fro		Man B-fah	tor	Maryland Balti	.more	V	voodlav	vn						1 ☐ Yes 2 💢	No
Edward  J. Roberts  Florence  Harker  19a. Informant's NamelRelationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Mr. N. Craig Cutter – Nephew  20a. Membrod of Disposition  12b Busial 2   Clemation 3   Removal from State  12b Busial 2   Clemation 3   Removal fro		or 28	Olre								1			ountry?	
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Edward  J. Roberts  Florence  Harker  19a. Informant's NamelRelationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Mr. N. Craig Cutter – Nephew  20a. Membrod of Disposition  12b Busial 2   Clemation 3   Removal from State  12b Busial 2   Clemation 3   Removal fro	2	urs af al', or	by		If Yes, Giv Year or Da	ites:		1 ☐ Yes 2 💢 No	Specify:			Spe	ecify:	White	
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Edward  J. Roberts  Florence  Harker  19a. Informant's NamelRelationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Mr. N. Craig Cutter – Nephew  20a. Membrod of Disposition  12b Busial 2   Clemation 3   Removal from State  12b Busial 2   Clemation 3   Removal fro	7	vithin ne. han "	Jdm	Elementary/Secondary (0-12)	College (1	-4or 5+)	`life. I	DO NOT use retired,	)			Commi	ıni+v	Sanuica P	1120
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Physician // Redical Examiner    Physician // Redical Examiner   Physician // Physic		mit. F partme sortar / injur				Λ			s of Facility						
Physician (Medical Examiner    Medical Examiner	ñ	Pe Pe Pe		I tau I by	cutal.	Je.				, Ind	530	5 Har			
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Sequentially list conditions, if any, leading to Immediate graphing and the part of the pa		/Medical		disease or condition					M						
Cause. Clisease or injury that initiated events resulting in death) Last    Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in death) Last   Cause. (Disease or injury that initiated events resulting in the underlying cause given in Part I.   Cause. (Disease or injury that initiated events resulting in the underlying cause given in Part I.   Cause. (Disease or injury that initiated ev			er	Sequentially list conditions, if any, leading to immediate	b	cov pu	uence of):	ale							
Section   Sect		cuted nd ransit	amin	cause. Enter Underlying Cause (Disease or injury that initiated events	6										
IFFEMALE:   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown   9   Unknown   Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death   1   Yes   2   No   3   Probably   4   Unknown   25e. Was case referred to medical examiner?   1   Yes   2   No   1   Yes	Ď,	oe exe cian a ourial-l		resulting in death) Last	Due to (	or as a conseq	uence of):								
9 Unknown  1 Yes 2 No  1 Yes 2 No  28a. Date of Injury  (Month, Day Year)  1 Yes 2 No  28b. Time of Injury  Month, Day Year)  1 Yes 2 No  28d. Describe how injury occurred  1 Yes 2 No  1 Yes 2 No  28d. Describe how injury occurred	200	physi s the t			d										
9 Unknown  1 Yes 2 No  1 Yes 2 No  28a. Date of Injury  (Month, Day Year)  1 Yes 2 No  28b. Time of Injury  Month, Day Year)  1 Yes 2 No  28d. Describe how injury occurred  1 Yes 2 No  1 Yes 2 No  28d. Describe how injury occurred		nding use as	n/Me									23d.	. Date of de	livery	
Chronic dostuctive pulmonary disease    1   Yes 2   No 3   Probably 4   Munkr	n	ie death the atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregn	ant at time of d							Month	Day Year	
24a. Was an autopsy performed? 1 Yes 2 No  25. Was case referred to medical examiner? 1 Yes 2 No  25. Was case referred to medical examiner? 1 Yes 2 No  26. Place of Death (Check only one)  27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at York?	7	that the			ons contributing to de	ath but not res	ulting in the u	nderlying cause give	en in Part I.		23e. Did to	bacco use	contribute to	the cause of death?	,
25. Was case referred to medical examiner?  1   Yes   25   No	rds	equires en sign ould be	ed b	chronic	obstructi	ve puin	nonan	c diseas	e		1 🗆 Y	es 2□N	lo 3∏P	robably 4 Unkno	wn
25. Was case referred to medical examiner?  1   Yes   25   No	Zecc	e law re has be je 2 sho	mplet								autops	sy	prior to	utopsy findings availa completion of cause o	ble of
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C C C C C C C C C C C C C C C C C C C	5	ysicia s cert direct	o B	examiner?		npatient 2	ER/Outpatier	nt 3 DOA Othe	20				Other (Spe	ocify)	
2   Accident 3   Suicide 4   Homicide   Street and Number or Rural Route Number, City or Town, State)   291. Location (Street and Number or Rural Route Number, City or Town, State)   292. Certifier (Check only one)   293. Certifier (Check only one)   294. Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		ng Ph fter th ineral		27. Manner of Death	28a. Date of						8d. Describe h	ow injury oc	curred		
286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  287. Cotation (Street and Number of Rural House Number, City or Town, State)  288. Cocation (Street and Number of Rural House Number, City or Town, State)  289. Cocation (Street and Number of Rural House Number, City or Town, State)  280. Cocation (Street and Number of Rural House Number, City or Town, State)  281. Cocation (Street and Number of Rural House Number, City or Town, State)  282. Cocation (Street and Number of Rural House Number, City or Town, State)  283. Cocation (Street and Number of Rural House Number, City or Town, State)	<u>S</u>	tendii leath. tor: A the fu	catio	2 Accident investig	gation				Yes 2□I		01.11 (0			- Control Market	
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e e e e e e e e e e e e e e e e e e e		Hospita 24 hours Funeral xely filled		(Check only 2 Medical	Examiner: On the ba	asis of examina	owledge, deat ition and/or in	h occurred at the tim vestigation, in my op	ne, date an pinion, dea	d place, a th occurre	nd due to the c ed at the time, d	ause(s) and late and pla	d manner as	s stated. e to the cause(s)	
5 E 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)		other of the omple	Mec	29b. Signature and title of certifie		otatod.					t t	9d. Date si	gned (Mon	th, Day, Year)	
hange of high 100 0000507 November 29,2004		->-0		1 pang				0	00060	050	7	Novem	nher	29,2004	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mayioy Mejig, MD		10		30. Name and address of person	who completed caus	e of death (Iten	n 23a) (Type,	Print) Maryi	OY M	rejia	MD			<u> </u>	
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State Registrar  NOV 3 0 2004  State Registrar	* k*			NOV 3 0 2	304 24	Both to the st	B	Docked!							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#26, perMD 6837, 11730/04 TI
State of Maryland / Department of Health and Mental Hygier 100 14 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year D4 **Physician** 4 SANDS 12:08AM H/Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A STREET S. CULVER BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Months Days Hours Min 1**⊠**M 2□F 218-44-22 57 Yrs. MD 09.02.1941 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits HOWARD ELLICOTT CIT 1 ☐ Yes 2 ☑No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SPRING MEADOW DRIVE 21042 3745 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 梵Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 25 No Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CHILDREN'S COUNSELING HOUSE MANAGER 12th amile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EDLO SANDS LILLIAN E. NAUACE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20716 RHONDA WILLIAMS 3512 EMPEROR COURT BOWIE MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 29 CROWNSVILLE, MD CROWNSVILLE <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funaral Service Lic 22 22. Name and Address of Facility
VALIGHN C. GREENE FUNERAL SERVICES augh SISI BALTIMORE NAT'L PIKE BALTIMORE, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pancreatic Cancer stastat disease or condition resulting in death) Du to (or as a consequence of): PANCREATIC CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 KNo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) House Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 X No 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examine physician a s the burial-1 Physician/Medical as attending p for use as the ģ signed k þ Completed certificate has page 2 director, 0 this funeral After Director:

**Funeral** 

Director

"naturel", or Items 23s or 28s-f ehow saical Examiner must be notified at

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72 hours after death with the Maryland

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permit. Pages 1 and 2 sh Department of Health and Importent: if item 27 is n any injury or other treum once.

Physician

Examiner

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To the Hospitel or Attending

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State Registrar

Medicai

/Medical

Baltimore, Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

COLUMBIA MD

29b. Signature and title of certifier

4 Homicide

(Check only one)

FNINARD

29a. Certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11065

31. Date filed (Month, Day, Year)

NOV 3 0 2004

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32. Registrar's Signature

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PATUXENTPRKNY

		-	For State Registrar	State of Ma	ryland	d / Depa	artment rtificate	of He	ealth a	ind Me	ntal Hy	giene 0	04	377	36
	Physicia		1. Decedent's Name (First, Middle, Las							2	Date of Dea	er 25,	Year	3. Time of E	Death
	/Medic	al	Max Leo Somers,  4a. Facility Name (If not institution, give				4b. City, T	oum or l	ogation of		Novemb		2004 ity of Death	1537	М
	Examin	er	Upper Chesapeake		ente	r		. Air		Death			rford		
	Funeral		5. Social Security Number 6. Se	7. Age		ast birthday)	If Under	Year Days	If Under 2	24 Hrs. 8	Date of Birt	h y, Year) 1924	9. Birthp	lace (State or try)	Foreign
	Director		212 20 3330	x <sup>M 2□F</sup> 80	)	Yrs.	I I I I I I I I I I I I I I I I I I I	Jujo	110010	J	une 15	, 1924	West	"Virgi	nia
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation						1	0d. Inside City	Limits
	ith the Marylar or 28a-f show	tor	Md. Harfor	d		Fal:	lston							1 ☐ Yes	2X No
	or 28	Direc	10e. Street and Number				10f. Zip					10g. Citizen o			
	a 23a	erai	3211 Hunt Road	12. Was Decedent E	iver in 11 S	S 12		alls		nin? (Spec	fy Ves or No.		ted St		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic evant. The Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1 X Yes 2 N  If Yes, Give  Year or Dates:			If Yes, speci		, Mexican,	, Puerto Ri	ify Yes or No can, etc.)	В	lack, White, cify: white	etc.	
5-0	72 ho natur	eted	15. Decedent's Ed (Specify only highest gra-	ucation de completed)		16a. Dece (Give	dent's Usual kind of worl DO NOT use	Occupati done du	ion iring most	of working	,	16b. Kind of	Business/Inc	Justry	
121	within ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		wright					stee	1		
<b>d</b> 2	filed Hygie othar ant.	Be Co	17. Father's Name (First, Middle, Last)		1	milli	WIIGHE		18. Mothe	r's Name (	First, Middle,	Maiden Sum			-
/lan	uld be Vental Irkad	To B	Unknown						Mida	a (un	known)	Somer	S		
, Maryland 21215-0036	and 2 sho alth and 27 is mu er traume		19a. Informant's Name/Relationship (7 Anna Somers/wife									er, City or Tow 21047			
ore	jes 1 a r of He if itam or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	CE	lace of Dispo emetery, cre	matory or ot	her place)		Da		20c. Location			
Baltimore,	iit. Pa artmen ortant: injury		<ul><li>4 □ Donation 5 □ Other (Specify</li><li>21. Signature of Funeral Service Licen</li></ul>		Hig	hview			1		/2004	Falls			
Ва	Depared Impo		Stefanie	. Rine	Re		Schin	unek Ma	cPha	éral II Ro	Home o ad, Be	f Bel,	Air: 1	1814	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lin	the death e.	. Do not en	ter the mode	of dying,	, such as	cardiac or	respiratory ar	rest,		Approximate Interval Betwo Onset and De	een
	Pnysician /Medical	4	Immediate Cause (Final disease or condition resulting in death)	a. CEREBR			4R	ACC	DO	UT				4 01	445
	Examiner			Due to (or as a			ASCU	LAR	1	SISE	ASE				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a			1120	7 (							
	acuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c											
760,	be executed sician and burial-transit	-E	, cooking in addition, and	Due to (or as a	Consequ	rence or).									
	ificate g phys as the	<u>.0</u>		. 0								1			
Вох 68	leath certificat attending phy I for use as th	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			⊒Ectopic pre	gnancy					Date of delive	•	ear
P.O. E	at the dea by the att	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4⊡Pregnant at 9⊡ Unknown	time of de	eath 5	Other (spe	ecity)					AIOHUH	Day 16	30.1
	es that thigned by		Part II. Other significant conditions of	ontributing to death bu	it not resu	ulting in the u	inderlying ca	use given	n in Part I.		23e. Did to	obacco use co	ontribute to th	e cause of de	ath?
Vital Records,	w requires been sign should be	ed by	CORONARY AR	TERY DI	SEA	, s∈					101	res 2□No	3 🗌 Prob	ably 4 Ur	nknown
ecc	e taw requ has been je 2 shouli	ompieted	PROSTATE CA	WCER							24a. Was autop	sy	prior to cor	psy findings av	
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Vita	sician: Th certificate irector, pag	Be c	25. Was case referred to medical examiner?	Hospital:	at 2 🗆	ER/Outpatie	-1 2 00	_			Check only o	<i>ne)</i> dence 6 🗀 0	Othor (Coosis	a)	
of	ding Phys	n: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injur (Month, Day		28b. Time o		Bc. Injury a Work?	at			now injury occ		9	
j je	teath. tor: After the funer	atio	1 √Natural 5 ☐ Pending 2 ☐ Accident investigation	1	7607	anjury	М		es 2 □ i	No					
Division	al or Att s after de il Direct	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	iry - At ho :. (Specify	ome, farm, st	reet, factory	office		28	If. Location (S City or Tox		nber or Rura	l Route Numb	er,
) }	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edicai (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examinat	wledge, dear tion and/or in	th occurred anvestigation,	at the time in my opir	e, date and nion, deat	d place, ar th occurred	d due to the	cause(s) and date and place	manner as st e, and due to	ated. the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier	1	-		29c.	License	number			29d. Date sig	ned (Month,	Day, Year)	
			Mitshyan	kar ms				アベフ	W+		1	NOVEMB	er 26	5, 200	4
11	7/1/2	-	30. Name and address of person who	completed cause of de	. /	1 23a) (Type ORTH	Print)	MUE	RE	211	e M	D 21	0/4	,	
l	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra			par the	1		111	- 10		- 7		
	Regist	rar	NOV 3 0 2004	1 may	Par	14	vienz								

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** SHAVER FSSIE MAE 10:04PM 04 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 200 SUTER ROAD BALTIMORR BALTIMORR If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1 M 2 XF 6 Yrs 238-66-7089 . [1] Director Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits item 27 la marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Martical Examination to be multilled at BALTIMORE MD BALTIMORE 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. SUTER 200 21228 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: ģ Specify: BLACK 3 Widowed 4 Divorced permit. Pages 1 and 2 should ba filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 Ia marked other than "natural", Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HEALTHCARR - CARR WORKER 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EMMA CHAMBERS CHAPMAN CAPLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROAD BALTIMORE, ALD 21228 JAMES F. SHAVER 200 SUTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 2 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 11.27.2004 BALTIMORE, MD ARBUTUS 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility VAUGHT C. GREENE FUNERAL SERVICES 5151 BALTIMORE NAT'L PIKE BALTO. MD Z1729 any in 23a. Part Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificata be exacuted as the burial-transit Due to (or as a consequence of P.O. Box 68760, attending physician for use as the buria Physician/Medicai 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death Yes the detached 9☐ Unknown 9 Unknow ģ signad Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by be 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other me Residence 6 Other (Specify)
28d. Describe how injury occurred 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 70 4 Nursing Home 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28c. Injury at Work? 28b. Time of Certification: 5 Pending Natural 1 □ Yes 2 □ No Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medicai completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #NU &21 N EU+aw Street Sug 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 3 0 2004 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 0 0 37738 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 29, 2004 Tessie Florence Saynuk 11:12 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Quail Run Assist Living Belair Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Birthptace (State or Foreign Country) Funeral Months 1 ☐ M 212 F 93 Yrs. 219-30-5418 Director April 30,1911 PA. Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2√2 No Director Baltimore MD. Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1931 Stanhope Road 21222 USA or items 23a Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3€Widowed 4 □ Divorced 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Depurtment of Health and Mental Hygiene. Impurant: If item 27 is marked other than "rany injury or other traumatic awant the second stress." Elementary/Secondary (0-12) College (1-4or 5+) 8 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Rafalko Tekla Kaczor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John P. Saynuk 1526 Cedarwood Drive, Belair, MD. 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition December 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Holy Rosary Cemetery 3, 2004 Dundalk, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Least consective Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be execu Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a Yes 2 100 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 'OP 1 ☐ Yes 2 ☐ No 2 UNO tal or Attending Physician: T is after death.

ai Director: After this certificat ed in by the funeral director, p? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Cother 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pendina 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 n. Custles 72220 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopkins as white March 4924

State

Registrar

31. Date filed (Month, Day, Year)

NOV 3 0 2004

Degistrar's Signature

Physician /Medical Examiner  1. Decedent's Name (First, Middle, Last)  Elizabeth Veronica Smith  4a. Facility Name (If not institution, give street and number)  Regency Park Assisted Living  Gambrills	November	Day Year	
Medical Examiner   E	November	07 0001 10 0	eath
Examiner	eath		2a <sup>M</sup>
Regency Park Assisted Living Gambrills	odui	4c. County of Death	
		Anne Arundel	pr 1
	Hrs. 8. Date of Birth (Month, Day, Ye. April 15,	ar) 9. Birthplace (State or I Country) Maryland	r-oreign
Usual Residence of Decedent	APILI 13,	1)21 Halyland	
10a. State 10b. County 10c. City, Town or Location		10d. Inside City	
Maryland Anne Arundel Gambrills		1 ☐ Yes 2	
Maryland Anne Arundel Gambrills    Top   T		Citizen of What Country? nited States	
The state of the s	? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.	
U = 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No Specify:	,	Specify: White	
S 3 Widowed 4 Divorced Year or Dates:	100		
Second   S	working	. Kind of Business/Industry	
College (1-4or 5+) 1+ Personnel Administr	cation H	ospital	
17. Father's Name (First, Middle, Last)  18. Mother's  19. Solve and Solve a	Name (First, Middle, Maid	den Sumame)	
Charles Schemmel Edna N	1cClelland		
Tr. Father's Name (First, Middle, Last)  17. Father's Name (First, Middle, Last)  18. Mother's  Charles Schemmel  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of 1689)  Donald Gully - Son  1689 Camden Court - A	r Rural Route Number, Cit	ty or Town, State, Zip Code)	
Donald Cully - Son 1689 Camden Court, A			
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)		Location - City or Town, State	
Balto./Wash. Crem. 12-	-3-2004 La	urel, Maryland	
20a. Method of Disposition    Description   Commeter, crematory or other place	ome of Caton Jenue, Caton	sville, Inc. sville, MD. 2122	8
23a. Pat 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as car show, or head failure. List only one cause on each line.		Approximate Interval Between	een
Immediate Cours (Fing)	24	Onset and De	ath
/Medical resulting in death)  Due to (or as a consequence of):	_	1 3 1	1
Examiner  Sequentially list conditions.  b. End Step Dementia	a´	may 4	VI
Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		L.	,
that initiated events resulting in death) Last  Due to (or as a consequence of):			
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tifficate as the as the dedic			
So to the second transport of		23d. Date of delivery	
1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify)		Month Day Ye	ar
O the second of		1.27	
6 se co co co co co co co co co co co co co		co use contribute to the cause of dea	
w requires we require sign should be	1 🗆 Yes	2 No 3 Probably 4 Un	known
0 x x x x x x x x x x x x x x x x x x x	24a. Was an autopsy	24b. Were autopsy findings av prior to completion of cau	railable use of
The Page Page Page Page Page Page Page Pag	performed 1 □ Yes 2 ☑	? death? No 1 ☐ Yes 2 ☐ No	
25. Was case referred to medical examiner?  1	Death (Check only one)	A	
L S 55 E TOTO LA TOTO	ng Home 5 Residence 28d. Describe how in		,
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To see the control of		and Number or Rural Route Number	er,
27. Manner of Death  1. Sent Natural  2	City or Town, St	tate)	
29a. Certifier  (Check only)  29a. Certifier  (Check only)  29 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death of the basis of examination and/or investigation, in my opinion, death of the basis of examination and/or investigation.			
and manner stated.  29c. License number	29d.	Date signed (Month, Day, Year)	
D 40519		1-29-04	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mus har Monanmed Muskurge	Gamer	ills md.	
State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature  40V 3 0 2004	10		

DHMH 17 Rev 1/2001

		1 - State Registrar		of Marylan	d / Depa		of H	ealth a		lental Hyg		04	37740
Physicia	an	1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea	ıth	Year	3. Time of Death
/Medic	al	LAVON SMITH  4a. Facility Name (If not institution	give street and n	umber)		4h City 1	Town or	Location o	of Death	NOVEMB1		2004	10:46pM
Examin	er	JOSEPH RITCHI					LTIM		, Dodin			N/A	
Funeral		5. Social Security Number	6. Sex 1ÅM 2□ F	7. Age (In yrs. 80	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 11-10-	Year)	9. Birthr	place (State or Foreign oftry) TH CAROLINA
Director		249-28-9189 Usual Residence of Decedent		00	113.					11-10-	1924	5001	IN CARULINA
aryland show	_	10a. State 10b. County			y, Town or Lo							1	10d. Inside City Limits 1⊕ Yes 2 □ No
the M 28a-f	recto	MD . N/A		B	ALTIMO	10f. Zip	Code				10g. Citizen	of What Cour	
th with 23a or	Funeral Director	903 BURNT EME	ER CT.			2	1208	3				USA	4)
er deat	uner	11. Marital Status	Armed F		.S. 13.	Was Deced If Yes, spec	ent of Hi ify Cubar	spanic Orig n, Mexican	gin? (Spe	ecify Yes or No- Rican, etc.)	14. F	Race - Americ Black, White,	
hours after	by F	1 ☐ Never Married 2 ☐ Marr 3 🔀 Widowed 4 ☐ Divorced	ied 1, Yes If Xes, G Year or	2 □ No Sive Dates:		1□Yes 2	.⊠ No	Specify:			Spe	cify: BLA	ACK
Ifid X IX 13-UU30 be filed within 72 hours after death with the Maryland the Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be motified at	Completed	15. Deceden (Specify only higher		()	16a. Dece	dent's Usua kind of wor DO NOT us	i Occupa k done d	ation during most	t of worki	ng	16b. Kind of	Business/In	dustry
within sne.	ldmc	Elementary/Secondary (0-12) -12-	College	(1-4or 5+)		DO NOT US INDRYM		)			KENC	OTT CO	)PPER
id be filed ental Hygi ked other ic event, I	Be C	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle,			
should bank Ments marked umatic ex	To	SAXON SMITH	<u></u>							RICHARI			
2 6 2 8		19a. Informant's Name/Relations EARLENE CROXT		TER)		-				<i>il Route Numbe</i> OWINGS I			AND 21117
os 1 and 3 tem 27 item 27 other tr		20a. Method of Disposition	0. TTD 16	20b. F	_  Place of Dispo cemetery, crei	sition (Nam	e of her place	θ)	11-35	0=2004	20c. Locatio	n - City or To	own, State
DESILLIMOT  Servit. Pages Department of  mportant: If it  any injury or or  ance.		1 □XBurial 2 □ Cremation '4 □ Donation 9 □ Other (S	pecify)	GAR	RRISON	FORES	T VE	ETERAI					MARYLAND
DEILLIMORE permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service	dicenses JONA	THAM D.						LLIPS F			AND 21217
	1	23a. Part1. enter the disease, or shock, it heart failure. List	complications that	caused the deat									Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	orly one cause on	NOV	MAK	1/2							Opeet and Death
/Medical Examiner		resulting in death)	Due to	o (or as a conseq	uence of):								W-711-0
	er	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a conseq	uence of):								
cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b> a										
fou, e be executed scielan and e burial-transit	cal Ex	resulting in death) Last	Due to	o (or as a conseq	uence of):								
COIDS, F.O. BOX 08/00,  w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	_		d				_				7,1		
th cert tendin	Physician/Med	1F FEMALE: 23b. Was decedent pregnant in the past 12 months?		utcome of pregna		∃Ectopic pre	egnancy					Date of delive	ery Day Year
he death the atter	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Preg 9☐Unk	gnant at time of d nown	leath 5	Other (spe	ecify)					WORK	Day Tour
ords, F.C. requires that the een signed by th hould be detache	by Ph	Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlying ca	ause give	en in Part I.	,	23e. Did to	bacco use co	ontribute to the	he cause of death?
ecords law requires as been sign	ted b	- MA	- ) = 4			1. 2.		<u>-</u>		1 🗆 Y	es 2 🗆 No	3 Prob	pably 4 Unknown
e 2 sh	ompleted	_ CINN	and	Of P	LUST 6	THE		_		24a. Was a autop perfor	sy	b. Were auto prior to co death?	psy findings available mpletion of cause of
VICAL MEC sicien: The law s certificate has b lirector, page 2 s	e Col	25. Was calle reference medica	W Th	TUM	7			26 Place	of Death	1 Yes	2 No	1 🗆 Yes	2 No
SION OF VITA tending Physicien: leath. tor: After this certific the funeral director,	To B	examiner? 1 Tes 2 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DO	A Othe	20		me 5 Resid		other (Specif	n Harrice
_ = -		27. Mann of Death 1 Natural 5 ☐ Pendir	ng (Mo	e of Injury onth, Day Year)	28b. Time o Injury	f 21	Bc. Injury Work	rat <br Yes 2 □ I		28d. Describe h	ow injury occ	curred	"
VISION Attending or death. ector: Atte by the tune	ficat	2 Accident investi	nor be 28e. Plac	ce of Injury - At h	ome, farm, st			163 2 []				mber or Rura	al Route Number,
Lal or /	Certification:	4  Homicide determ	buil	ding, etc. (Specil	(y)					City or Tow	n, State)		
DIVISIG To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical	ng Physician: To the Examiner: On the	basis of examina									
To the I within 2 To the I complet	Med	one) 29b. Signature and title of certifie		nner stated.		29c	. License	a number		2	29d. Date sig	ned (Month,	Day, Year)
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511		30. Name and address of person	who completed car	use of deat) (Iter	n 23a) (Tyg).	Print	.)	nel	18	1/ 8	111	4)00	Wilzinia
Sta	ate .	31. Date filed (Month, Day, Year,	10/11/32.	Registrar's Signa	ature	10/6	111	UG	16	1 840	11/14	weg,	MXHS
Registi		NOV 3 0 20	04 Sen	Direct .	B x	pork	2						

State of Maryland / Department of Health and Mental Hygien [ ] For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** November 26, Wilbert Smallwood 2004 1:00 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1,8 M 2□ F 69 Yrs. Jun 10, Director 579-44-0217 DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 30 Acorn Circle #201 21204 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates 5 0 - 5 2 2 should be filed within 72 hours after deal end Mental Hygiene. Is marked other than "natural", or Itame 3 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Government Elementary/Secondary (0-12) College (1-4or 5+) 4 Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Wilbur Smallwood Annie Elizabeth Blair 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 a Department of Heelth er Important: If Item 27 is any Injury or other trau once. 30 Acorn Circle # 201, Towson, MD 21204 Nicole Smallwood/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nov 27 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, MD 2004 Chesapeake Crematory \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Mool 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic LUNGCA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequenca of) Examiner Igned by the ettending physician and be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an autopsy performed. 1 ☐ Yes 2 A No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Leath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Dire 4 | Homicide within 24 hours a
To the Funeral C 1 Dentifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0:1-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahmood 2300 31. Date filed (Month, Dal), Year)

NOV 3 0 2004 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere For State Registramend ITEM #26 PER FH G837 11/30/04 JH Reg. No 2. Date of Death 3. Time of Death Month Day Year **Physician** 9:46 AM AKOLUN Nov Empel 28 200 /Medical 4a. Facility Name (If not inditution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner eco Vi. 0 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6 Sex **Funeral** Months Min. Days Hours 1 ☐ M 2 🛛 F 56 218-46-9129 Yrs Director Maryland Usual Residence of Decedent the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No BAltimore Director MD NA 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 1648 Ruxton Avenue or items 23a 21216 **IISA** Pages 1 and 2 should be filed within 72 hours after death in nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "neturel", or items 23s Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Administrative 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be O'Neal V. Stinnett Sr. Ella B. Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1648 Ruxton Avenue Baltimore, MD 21216 Annette M. Stinnett/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State ö Department of Important: If any injury or once. St. James Cemetery \* 4 □ Donation 5 □ Other (Specify) 12-03-04 New Windsor, MD 21. Signatur Funeral Arvice Licensee 22, Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TyochAdi /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No for 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2□ No 1 Yes 2 4 1 Tyes Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence P 1 Tyes No 6 Other (Specify) this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manne Certification: After Natural 5 Pending investigation s after dec. 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospital within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier 30. Name and address person who completed cause of death (Item 23a) (Type, Print) Baltimore, Md 000 0

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

NOV 3 0 2004

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () ITEM #8 PER FH G838 12/08/04 JH Reg. No. 2. Date of Death 3. Time of Death **Physician** Gladys G. Simmons November 0233 AM ZOON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmore Huspital Backmore Cuty 8. Date of Birth **1928** (Month, Day **1** ear) 06-15-1<del>978</del> 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number Funeral 1 ☐ M 2 🛣 F Days Hours 220-20-4089 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore 1 XYes 2 No Director NΑ MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5257 Nelson Avenue 21215 **TISA** or Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. □Yes 2X No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: à 3 Widowed 4 Divorced Black. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Child Care Provider Health 17. Father's Name (First, Middle, Last) 11nknown 18. Mother's Name (First, Middle, Maiden Sumame) Be Annie Seagal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5257 Nelson Avenue Baltimore, MD 21215 Isaiah Simmons/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Owings Mills, MD 4 □ Donation 5 □ Other (Specify) Garrison Forest Veteran 12-03-04 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23e-Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of) Box 68760 ician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2010 1 Yes 2 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ ₩6 2 1 Impatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Phatural 28b. Time of 28d. Describe how injury occurred After 1 Certification: 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Suneral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year)
November 26, 2004 29c. License number 29b. Signature and title of certified P50693 who completed cause of death (Item 23a) (Type, Print) donai

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

forth

State of Maryland / Department of Health and Mental Hygiene \( \cap \cap 1 \).

			State of Marylan	Certi	ficate of	Death		g. No.	4 3//44
	Physician	1. Decedent's Name (First, Middle, Last	•				Dete of Deeth     Month	Day Yea	
1	/Medical	,	H. Simpson				Nov.	28, 2004	
	Examiner	4a Facility Neme (If not institution, give Manor Care Of Po			4	ib. City, Town, or Lo Potomac	cation of Deeth	4c. County of De	
		5. Social Security Number 6. Se		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgo	Birthplace (State or Foreign
	Funeral Director		OM 2√ F 8		Months Days	Hours Min.	8. Date of Birth (Month, Day, AUG 18,	1917 Vi	Country) rginia
	70	Usual Residence of Decedent	10. 03						
	anylar show	10a. Stete 10b. County		y, Town or Locat					10d. Inside City Limits 1 ☐ Yes 2 X No
	the M	Maryland Montgom	iery		thesda 10f. Zip Code		10	g. Citizen of What	Country?
	Sa or	61114 Namakagan R	Road			20816		USA	•
	ms 2 Lms 2	11. Marital Status	12. Was Decedent Ever in U, Armed Forces?	S. 13. Wa	s Decedent of H	ispanic Origin? (Span, Mexicen, Puerto	ecify Yes or No-		merican Indian,
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ② No If Yes, Give Year or Dates:	1	Yes 2 No	Specify:	nican, ecc.)	Specify:	White
5-0	72 ho	15. Decedent's Edu (Specify only highest grea	ucation de com <i>oleted)</i>	16a. Deceden	it's Usual Occup	ation during most of work	ing 1	6b. Kind of Busines	ss/Industry
2	aple Markin	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retired	1)		Wood & K	anah a
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au	Mental Harked of attic eve		E. Van Pelt				Margaret		
Maryland	shoul nd Me mark umati	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailing	Address (Street	end Number or Rur	al Route Number,	City or Town, State	e, Zip Code)
Σ	and 2	Gary Lucas/son		2910 (	Oakboro	Square	- Oaktor	NA 221	24
ore	of He fitem	20a. Method of Disposition 1 □ Burial 2 ☐ Cremetion 3 □ F	Removal from State	lace of Dispositi emetery, cremat	ion (Name of tory or other plac	xe)		0c. Location - City	or Town, State
altimore,	Pag tment tant: I	4 □ Donation 5 □ Other (Specify)	Met	ro Crema			1/29/04		ore, MD
Ba	permit Deper impor any In	21. Signature of Funeral Service Licens  homo  Thomas Gre	Lynn	<sup>22</sup> Cr 29	remation 99 Frede	ss of Facility Society crick Road	of Mary]	land, Inc	· 21228
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	cate be executed physician and the buniel-transit	Sequentially list conditions	b. Due to (or	r as a conseque	nce of):	4210	rious		7/(5
o,	cate be executed physician and the bunel-transit calcal Examin	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury							1
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Вох	attend for us						ant Bullet		
<u>o</u> .	let the death certing by the attending eleched for use elected.	Part II. Other significant conditions con	ntributing to death but not resu	uting in the unde	eriying cause giv	en in Pert I.			Probably 450 Unknown
<u>'S</u>	es the igned be de be de								
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Z.	The la						1□ Yes	2 <b>20</b> 00	1 ☐ Yes 2 ☐ No
ita	entifica ector, p	25. Was case referred to medical examiner?			7.		(Check only one	))	
5	hysic his ce al dire	1 ☐ Yes 2 No			3 DOA Oth	4 KNUTSING NO		nce 6 Other (S)	pecify)
E C	ing P	27. Menner of Death  1 Natural 5 Pending investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury Wor M 1 🗀	k? Yes 2□No	28d. Describe hov	w injury occurred	
Division of Vital	tial or Attanding Physician: al Officior: After this certific led in by the funeral director, Certification: To Be (	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street	t, factory, office		28f. Location (Str. City or Town,		Rural Route Number,
_	To the Hospital or Attanding Physician: The law within 24 burus effect death, within 24 burus effect death, conflicted has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	(Check only 2 Medical Exami	sician: To the best of my know iner: On the basis of exeminet						
	ithin 2 or the or the omple	one)  29b. Signature and title of cartified)	end manner stated.		29c. Licens	e number	29	d. Date signed (Mo	onth, Dey, Yeer)
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	/	- <del>    (</del> ()),	tao		1)3.	7797	-   <i>N</i>	OVEMB	EK,29,2004
	h	30. Name end address of person who c	ompleted cause of death (Item	1 23e) (Type, Pri	D3-	NSTON	- N	ROC	ER,29,2004 KVILLE,MD

Registrar

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		į.	1. Decedent's Name (First, Middle	, Last)				2. Date of Dea		3. Time of Death	
	Physicia		Joe	elle M. Stel	labotte			Month NOV.	20, 2004	12:10 P <sup>M</sup>	
	/Medic Examin		An English Name (If not institution aim stand and graphs)				or Location of Deat	h	4c. County of De		
	xamm	-	802 OLD ENGLI	SH COURT APT	3-D	BEL	AIR		HARFORD	)	
	Funeral Director		5. Social Security Number UNK		n yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day AUG 23,	9. B 1965 F	inthplace (State or Foreign Country) Lorida	
2	pug 💃		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits	
	within 72 hours after death with the Maryland ene. then "naturel", or Hems 23e or 28e-f show he Mcdical Examiner must be rotiffed at	ō								1 XYes 2 □ No	
	the A	Director	Maryland Har:	LOLU		Bel Ai	LL		log. Citizen of What 0	Country?	
	with B or	ä		1 0				'		Journay :	
	s 23	ra		sh Court, A				'naaitu Vaa as bla	USA	andon Indian	
	er de	Funeral	11. Marital Status	Armed Forces?	91 III O.3.	If Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puer	to Rican, etc.)	Black, Wh	14. Race - American Indian, Black, White, etc.	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Dates:		1□Yes 2XNo	Specify:		Specify: [	√hite	
8	"naturel", or	edt	15. Decedent		16a Dece	dent's Usual Occu	pation		16b. Kind of Busines	s/Industry	
15	in 72 in a	olet	(Specify only highes	st grade completed)	(Give	kind of work done DO NOT use retire	during most of wo	rking			
21215-0036	be filed within 72 ho ital Hygiene. id other than "natur event, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Н	omemake	er		Own Ho	ome	
	filed Hyg other	Ø.	17. Father's Name (First, Middle,	Last)			18. Mother's Nar	me (First, Middle,	Maiden Sumame)		
Maryland	12 should be filed within h and Mental Hygiene. 7 ie marked other than " traumatic event, the Mes	To B	Michael A.	Stellabotte	2		Glori	a F. Ga	skins		
JE V	s 1 and 2 should Health and Men item 27 ie marke other traumatic	_	19a. Informant's Name/Relations			ng Address (Street			r, City or Town, State,	Zip Code)	
Baltimore, Ma	2 = ~ .		Michael A. Stel	llabotte/Fathe	er 9346	132nd T	errace. I	ive Oak.	FL 32060		
	ges 1 and 2 t of Health If item 27 i		20a. Method of Disposition		20b. Place of Dispo				20c. Location - City of	or Town, State	
10	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 X Cremation 1 ☐ Donation 5 ☐ Other (S)	3 ☐Removal from State	Metro Cre		,	2/1/0/1	Baltimor	MD	
=	# 문문증 .		21. Signature of Funeral Service		2	2. Name and Addre	ess of Facility	24/04	Dartimor		
Ba	permi Depar Impo any ir		Edward A	Gregorchik	$r \qquad \qquad \begin{array}{ c c } D \\ A \end{array}$	aniels 16 F Hor	Funeral	Homes,	Inc.	32064 Live Oak, FL	
			23a Part1. Enter the disease, or							Approximate Interval Between	
	Physician /Medical Examiner	14	Immediate Cause (Final disease or condition resulting in death)	a. Narcotic a Due to (or as a c	consequence of):	apine Int	coxicatio	n		Onset and Death	
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O. Box	The law requires that the death certificate be executed at the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ yes 2 ☐ No 9 ☑ Unknown	23c. If yes, outcome of particle of the state of the sta	Fetal death 3	□Ectopic pregnand □ Other (specify) _	Sy .		23d. Date of d Month	elivery Day Year	
d'sp	ires that signed b	by	Part II. Other significent condition	ins contributing to death but n	not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	. /	to the cause of death?  Probably 4 □Unknown	
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Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0	her	ath (Check only on			
of	Phys this al dii	10 10	1X Yes 2 No 27. Manner of Death	1 ☐ Inpatient	2 ER/Outpatie	IL 3 DOA	4 🗀 Nursing r		ence 6 XOther (Sp ow injury occurred	TIT DOLLAR	
on		tion	1 Natural 5 Pendin 2 Accident Investig	Found, Day Y	ear) Formal	Wo	ork? ]Yes 2 <b>X</b> No	200. 20001.00 11	ow injury occurred	unk	
Division	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 X Could in determined	not be ined 11-30-04 28e. Place of Injury building, etc. (	- At home, farm, st			28f. Location (Si City or Town	treet and Number or P n. State) 802 0	Bural Route Number Ld English Ct	
	ospitel of hours af unerel Dunerel Dittel in the local light of the lo			Found at				bel Air,	, Ma		
	To the Hospitel or within 24 hours afte To the Funerel Dis completely filled in	Medical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the best of n Exeminer: On the basis of ex and manner stated	ramination and/or in	h occurred at the tivestigation, in my	ime, date and place opinion, death occi	e, and due to the curred at the time, d	ause(s) and manner a late and place, and du	as stated. ue to the cause(s)	
	To the within 2	Med	29b. Signature and title of certifie			29c. Licen	se number	2	9d. Date signed (Mor	nth. Day, Year)	
	⊬ s ⊢ ŏ		10.	Mr. Uhill	Mo	0.	C.M.E		NOV. 21	, 2004	
•			30. Name and address of person	, ,	th (Item 23a) (Type,	Print)				•	
			MARYAMTO	N. KORFI			, Baltim	ore, Mary	land 2120	<u> </u>	
	Sta Regist		31. Date filed (Month, Day, Year)		s Signature	porti					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier Certificate of Death 2 Date of Death 3 Time of Death Decedent's Name (First, Middle, Last) NOV. 227 **Physician** 3,20 AM 2004 Ε. SAPIR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WESLEY HOME BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (Sountry) | Nonths | Days | Hours | Min. | 02/22/1910 | POLAND 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🗷 F 94 113-18-8434 YES Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show ust be notified at Yes 2 No MD BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21209 2211 WEST ROGERS AVE USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Who If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2XNo Specify: Specify: WHITE à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **PSYCHOLOGY** PSYCHOLOGIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN SITA ROSEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4410 GREENWAY BALTO., MD. 21218. ALEXANDER SAPIR(G-SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Macremation 3 ☐ Removal from State GREEN MOUNT CREMATORY11/30/2004 BALTO. CITY, MD \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS 16924 YORK RD. M IS & SONS CO. MONKTON, MD. aredit Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherschote Carde Vascilen Distance Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? no Sensis Disease, Denertin, 1 Yes 2 No 3 Probably 4 nknown peen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 20 No certificate 1 Yes or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Certification: To Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this nours after death.

nerat Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral I To the Hospital 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar (Check only one)

31. Date filed (Month, Day

29b. Signature and title of certifier

32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) Type, Print)
ROBERT LIBERTS. W. 3708 BRINE Ms.

DHMH 17 Rev 1/2001

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month NICHOLAS SMYRNIOUDIS November 7:30ATHEMIS 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 205 East Joppa Road #1509 Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 6, 1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1**√X**M 2□ F Greece 212-30-6863 83 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code or Items 23a or 205 East Joppa Road #1509 21286 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2**X X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo White þ Specify: 3X Widowed 4 □ Divorced "natural" **Be Completed** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. Accountant Public Accounting permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygi Important: If Item 271s marked other any injury or other traum.... other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Smaraghna Stathakis Themistocles John Smyrnioudis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicholas T Smyrnioudis Jr Son 324 Presway Road Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Greek Orthodox Cemetery ☐Donation 5 ☐ Other (Specify) 11/24/04 Baltimore, Maryland ignature of Fun Say ice Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed hysician and the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 □Unknown 1⊠Yes 2 No Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 🗌 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No investigation s after death 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Hospital 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIGNOS TOWSON, MD 21 ELO 5 780 32. Remistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Ma	aryland / D	epartment <i>Certificate</i>	of Health ar of Death	nd Mental H	ygi <b>zne</b> () Reg. No.	14 37	748
	Diam'r.		1. Decedent's Name (First, Middle, L	ast)				2. Date of E	Death Day	3. Tir	me of Death
	Physicia /Medic		Beatrice B.	ber 22,	2004 9:	15P <sup>M</sup>					
	Examin		4a. Facility Name (If not institution, ga	ive street and number)		4b. Cily, T	own, or Location of	Death	4c. Cour	nty of Death	
			Carroll Hospit		- // last bird		estminste Year   If Under 24		Car		
	Funeral	Ì		Sex 7. Age 1 ☐ M 2 🗶 F	e (In yrs. last birt		Days Hours	Min. (Month, L	Day, Year)	9. Birthplace (Si Country)	
	Director	-	237-26-8808 Usual Residence of Decedent		82			April	15,1922	L	<u>A</u>
	/land	Ì	10a. State 10b. County		10c. City, Town	or Location				10d. Insi	de City Limits
	Man 9-feb	tor	MD Balt	imore	Re	istersto	wn			1 🗆	Yes 2∭XNo
	h the	Director	10e. Street and Number	Z.M.O.Z.O	1,0	10f. Zip (			10g. Citizen o	of What Country?	
	th wit	ai	918 Shirley Ma	nor Road			21136		USA		
	ems erms	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decede If Yes, specif	ent of Hispanic Original by Cuban, Mexican,	n? (Specify Yes or Neuerto Rican, etc.)	14. R	lace - American India lack, White, etc.	an,
36	filed within 72 hours after deeth with the Maryland Hygiene. ther then natural', or ttems 23a or 28e-f ehow ont, the Madical Examiner must be notified at	by Fu	1 Never Married 2/ Married	If Yes, Give **	No	1 ☐ Yes 2	No Specify:		Spec	cify:	
21215-0036	hour tural	d b	3 Widowed 4 Divorced	Year or Dates:	163	Decedent's Usual	Occupation		16h Kind of	White Business/Industry	
<u>.</u>	in 72	Completed	(Specify only highest g	rade completed)		(Give kind of work life. DO NOT use	done during most of	of working	TOD. KING OF	Business/industry	
72	lene.	mo	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Hous	sewife		Own	n Home	
g	othe othe	Be C	17. Father's Name (First, Middle, Las	st)			18. Mother's	s Name (First, Midd	le, Maiden Sum	ame)	
lar	Aenta Aenta rked ric ev	To E	LEONARD S	PANN			MA	BEL (	ZAM BE	= 4	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23a or 28e-f ehow appringnty or other traumatic event, the Madical Examinational be notified a sonce.		19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address (	Street and Number	or Rural Route Num	ber, City or Tow	m, State, Zip Code)	
Σ	and 2 ealth n 27 l		Raymond J. Snyd	er Husban						wn, MD 21	
Baltimore,	of He		20a. Method of Disposition 1 Burial 2 Cremation 3	☐Removal from State	20b. Place of cemeter	Disposition (Name y, crematory or oth	e of ner place)	Date	20c. Location	n - City or Town, Sta	ite
Ĕ	Pag ment ent: lury c		`4 ☐ Donation 5 ☐ Other (Spec	cify)	Carro1	1 Cremat:	ion 1	1/24/04	Hampst		
3a	Depart Depart Import any in		21. Signature of Funeral Service Lic	ensee	all.		Address of Facility			erstown Ro	
	0.07 = 6 0t		repuer	irn. P	DI SKING		uneral Ho			n, MD 2113	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	ly one cause on each lin	ne.	ot enter the mode	of dying, such as ca	ardiac or respiratory	arrest,		ximate al 8etween and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	D 21.2					jo	days
П	/Medical Examiner		Tooling in doubly	0	a consequence of	of):					
		<u>_</u>	Sequentially list conditions, if any, leading to immediate	b	a consequence of	of):					
17.	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	(h. ()	•	,					
Ć,	exect n and ial-tra	Exal	that initiated events resulting in death) Last	Due to (or as	a consequence o	of):					
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_	Ch et										
Вох	eath certifi attending for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1☐Live birth	of pregnancy 2 Fetal death	3 □Ectopic pre	anancv			Date of delivery	V
Э.	e dea he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐ Unknown		5 Other (spe	cify)			Month Day	Year
P.O.	res that the death cer igned by the attendir be detached for use	Phy	9 Unknown					00 - Pi	1 12		
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oro	w require been si should I	ted	// / / / / / / / / / / / / / / / / / / /						1162 513140	3 1 TODADIY	+ LIGHKHOWH
ec	a law	npie							opsy	<ul> <li>Were autopsy find prior to completion</li> </ul>	ings available tof cause of
E		Co							formed? 2 No	death? 1 Yes 2 No	,
Vita	ician; Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Others	of Death (Check only			
ot	Phys this ral dir	To:	1 ☐ Yes 2 ☐ No  27. Magner of Death	1 ☑ Inpatie		ime of 28	4 19015	sing Home 5 Re	sidence 6 00 s how injury occ		
on	ding After fune	tion	1- Natural 5 ☐ Pending	(Month, Da		njury M	lc. Injury at Work? 1 ☐ Yes 2 ☐ No		o iii(a.) ooo	31700	
Division of Vital Records,	Attending Physician: r death. sctor: After this certific by the funeral director.	fica	3 ☐ Suicide 6 ☐ Could not	be Geo Place of Ini	ury - At home, fai	rm, street, factory,		28f. Location		mber or Rural Route	Number,
Ω	after after Dire	Certification:	4 Homicide	building, et	c. (Specify)	,		City or T	own, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.			Physician: To the best							
	n 24   n 24   he Fu	edicai	(Check only 2 Medical Ex	aminer: On the basis of and manner sta		d/or investigation, i	in my opinion, death	occurred at the time	e, date and place	a, and due to the car	1SB(S)
	To the comp		29b. Signature and title of certifier	26 4		29c.	License number		29d. Date sign	ped (Month, Day, Ye	ar)
)			your de	Mon,		10	1 6 20 -		11/2	2/07	
	(		30. Name and address of person wh	o completed cause of d	leath (Item 23a) (	Type, Print)	1 1	P. 1.	1	m1 -	7/
	)		30. Name and address of person who all the filed (Month, Day, Year)	011 117	Daine	18 60-1	+- · · · · · ·	70 (1)7-1/	13-10	- 4 2/1.	, (
	Sta Registi	ite ar	NOV 3 0	2004 32. Hegistr	ai s Signature	D Sp	call				

		= State Registrar	Maryland / Depa <i>Cer</i>	tificate of Death	Reg. N	lo.	7749	
Physicia /Medic		Decedent's Name (First, Middle, Last)     FLORENCE	I.	SHAPIRO		26, 2004 4:		
Examin		4a. Facility Name (If not institution, give street and numb	oer)	4b. City, Town, or Location of Death		c. County of Death	Г	
- Farmerick		BRIGHTWOOD ELDERCARE  5. Social Security Number 6. Sex 7.	. Age (In yrs. last birthday)	LUTHERV I If Under 1 Year If Under 24 Hrs.		BALTIMOR  9. Birthplace (Country)		
Funeral Director		212-18-9922 ¹□ <sup>M</sup> <sup>2</sup> ₹ F	82 Yrs.	Months Days Hours Min.	B. Date of Birth Month Bay, Yea DEC. 19, 19	21 Country)	MD	
/lend		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			side City Limit	
e Mary le-f sh lifted	ctor	MD BALTIMORE		PARKVILL			□Yes 2 X N	
MITH IT	Director	10e. Street and Number		10f. Zip Code 21234	10g. 0	Citizen of What Country?	Λ	
ms 23	Funeral	3209 WILLOUGHBY ROAD  11. Marital Status  12. Was Deced	dent Ever in U.S. 13. y	Vas Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen	pecify Yes or No-	14. Race - American Inc. Black, White, etc.		
illed within 72 hours after death with the Maryland Hygiene. Hygiene, the Hygiene than "neturel", or Items 23a or 28e-f show ant, Item Medical Examiner must be notified at each	by Fur	1 Never Married 2 Married 1 Yes, 2 If Yes, Give Year or Dat	Z (XNo	1 ☐ Yes 2 💢 No Specify:	o rican, etc.,		ITE	
"neture	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking 16b.	Kind of Business/Industry		
inould be filled within 72 no ad Mentel Hygiene. marked other than "netu matic event, ILA Medical	omo	Elementary/Secondary (0-12) College (1-2	TEACHI		E	DUCATION		
	Be	17. Father's Name (First, Middle, Last)	0 D D 0 M		me (First, Middle, Maid	en Sumame) ROBIN	CON	
2 should be th and Mentel 7 le marked ( treumatic ev	٦	HARRY  19a. Informant's Name/Relationship (Type, Print)	ABRAMS	SON KATE  ng Address (Street and Number or Ri	ural Route Number, Cit			
7 le		KENNETH SHAPIRO / SON		WILLOUGHBY ROAD				
Pages 1 and nent of Heelt int: If Item 2 iry or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Si		esition (Name of matory or other place)		Location - City or Town, S		
		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	BALTIMORI	E HEBREW CEM 11/2	The state of the s			
Departr Importa any inji		21. Signature of unional Service Citeriate		2. Name and Address of Facility SC 900 REISTERSTOWN_				
		23a. Part1. Enter the disease, or complications that cal shock, or heart failure. List only one cause on each				App Inter	roximate vai Between	
flysiciati		Immediate Cause (Final disease or condition resulting in death)	END STAGE			Oris	et and Death	
/Medical Examiner		Due to (o	or as a consequence of):					
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (o	or as a consequence of):					
and transi	Examln	that initiated events c.	or as a consequence of):					
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I he law requires that the death certi tte has been signed by the attending vage 2 should be detached for use a	Physician/M	230. Was decedent pregnant 1 Live bir	ant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year	
igned by be detact	/ Phy	Part II. Other significant conditions contributing to dea	ath but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cal	use of death	
been sign should be	ed by				1 ☐ Yes	2 No 3 Probably	4 Dunkno	
cate has been page 2 sho	Completed				24a. Was an autopsy performed 1 ☐ Yes 2 【X		tion of cause	
	Be Co	25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)	10 12 00		
etor,		1 ☐ Yes 2 💢 No Hospital: 1 ☐ In	patient 2 ER/Outpatier			6 Other (Specify)		
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nyelcien this certifi al director,	$\vdash$	1 Natural 5 Pending (Month	n, Day Yeer) Injury	M 1 Yes 2 No		treet and Number or Rural Route Number, n, State)		
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ore or Attending Projections urs after death.  stel Director: After this certification by the funeral director.	Certification; T	1 Natural 2	of Injury - At home, farm, str ig, etc. (Specify)  best of my knowledge, deat isis of examination and/or in	M 1 Yes 2 No	City or Town, S	tate) e(s) and manner as stated		
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or Attending Physicien iffer death. Director: After this certifi in by the funeral director.	edical Certification; T	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  1 Certifying Physician: To the tagency on the base and manner.	of Injury - At home, farm, str ig, etc. (Specify)  best of my knowledge, deat isis of examination and/or in	M 1 ☐ Yes 2 ☐ No reet, factory, office  th occurred at the time, date and place and p	City or Town, S e.e., and due to the causiurred at the time, date	tate) e(s) and manner as stated and place, and due to the	cause(s)	
olfel of Attending Phyeicien. urs after death. srel Director: After this certification by the funeral director.	edical Certification; T	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and latte of certifier  30. Name and address of person who completed cause	of Injury - At home, farm, string, etc. (Specify) best of my knowledge, deat sis of examination and/or in er stated.	M 1 □ Yes 2 □ No reet, factory, office  th occurred at the time, date and place restigation, in my opinion, death occurred at the time, date and place restigation, in my opinion, death occurred at the time, date and place restigation, in my opinion, death occurred at the time, date and place restigation, in my opinion, death occurred at the time, date and place restigation, in my opinion, death occurred at the time, date and place restigation, in my opinion, death occurred at the time, date and place restigation, in my opinion, death occurred at the time, date and place restigation, in my opinion, death occurred at the time, date and place restigation, in my opinion, death occurred at the time, date and place restigation, in my opinion, death occurred at the time, date and place restigation, in my opinion, death occurred at the time, date and place restigation, in my opinion, death occurred at the time, date and place restigation, in my opinion, death occurred at the time, date and place restigation, in my opinion, death occurred at the time, date and place restigation, in my opinion, death occurred at the time, date and place restigation at the time, date and place restigation at the time, date and place restigation at the time, date and the tim	City or Town, S i.e. and due to the caus- curred at the time, date 29d.	e(s) and manner as stated and place, and due to the Date signed (Month, Day,	cause(s)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear **Physician** 27, 3:05 P November 2004 Gary Lewis Stoker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 75€M 2□ F 52 1952 Maryland 216-56-8348 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🖾 No Director Maryland Harford Darlington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 2207 Shuresville Road 21034 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Pupil Schools Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Taylor Earl Stoker Maxine Zola 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 308 N. Paradise Road, Havre de Grace, MD 21078 Sandra E. Kave / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State `4 Donation 5 Dother (Specify) Bel Air Memorial Gardens 12-2-04 Bel Air, Maryland 22. Name and Address of Facility.
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee maile T-1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PATINE disease or condition resulting in death) noav Sequentially list conditions, if any, leading to immediate Examiner Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Roman Conten 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an Adlac a Any Monia Yes 2**K)** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 🗌 Yes

**Physician** /Medical Examiner use as the burial-transit P.O. Box 68760

**Funeral** 

Director

1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show

item 27

permit. Page Department of Important: If any Injury or once.

Pages 1 nent of H ant: If ite

Baltimore, Maryland 21215-0036

other traumatic event, the Medical Examiner must be notified at

page 2 s director, Be J. Certification: pell

Outer.	4 Nursing H	ome	5 Resid	dence 6	Other	(Specify)
njury at Work?		28d.	Describe h	ow injury	occurred	

S. Urnion ave.

red 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

NAIR

28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

1 Inpatient 2 ER/Outpatient

28a. Date of Injury (Month, Day Year)

20215

29d. Date signed (Month, Day, Year)

28/04

list out of me sigg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2.

KARMOCUAN DRA. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2 No

5 Pending

investigation

6 Could not be determined

27. Manner of Death

1 Natural

3 Suicide

29a. Certifier

Medical

State

Registrar

4 Homicide

(Check only one)

Accident

NOV 3 0 2004

32. Registrar's Signature

30 DOA

28c. i

After

within 24 hours after deat To the Funeral Director:

			For State Registrar	tate of Maryland / Dep Ce	partment of Health and I	Mental Hygien		37751
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  WILLIAM L. TIS	DALE			oay Year	3. Time of Death 4:30 PM
	Examin		4a. Facility Name (If not institution, give stre	et and number) SCOURT	4b. City, Town, or Location of Death	1 4	lc. County of Death	fimore
Ì	Funeral Director		145-24-623+	7. Age (In yrs. last birthday 2□F 78 Yrs.	/ If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 01.30.10	9. Birth Co.	hplace (State or Foreign untry)
	Maryland f ahow	or	Usual Residence of Decedent  10a. State  10b. County  Paltimit	10c. City, Town or L	ocation MSVIIIE			10d. Inside City Limits 1 ☐ Yes 2 ☑No
	with the 2 3e or 28e-	I Directo	10e. Street and Number 1109 Outlet Mills		10f. Zip Code 21228	10g. C	Citizen of What Co	
30	within 72 hours after death with the Maryland sne. than "natural; or flams 23e or 28e-f ahow than "medical Exert refinest by rediffer at	by Funeral	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 Yes 25 No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White Specify: B	ncan Indian, e, etc.
9500-6121	within 72 hou ene. than "natura	Completed	15. Decedent's Educati (Specify only highest grade co	on 16a. Dec (Giv life.	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired) ALL CARRIER	king	Kind of Business/I	Industry NEW YORK
land 2	be filed trial Hygie of other to other to other to other trial other trials.	To Be Co	17. Father's Name (First, Middle, Last) William V. Tisdale	NJA   N		ne (First, Middle, Maide	1- / 1	NCW TOPE
, Mary	and 2 should ealth and Men n 27 is marka ter traumatic		19a. Informant's Name/Relationship (Type, Helen G. TIS dale		ling Address (Street and Number or Ru L TIHR+ MINS C+.	ral Adute Number, City  CATO SVIII		
altimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: ff itam 27 is marke any injury or other traumatic <u>once.</u>		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Rem  4 □ Donation 5 □ Other (Specify)	oval from State	osition (Name of amatory or other place)	Date 20c.	Location - City or 1	
Balt	permit. Departr Importe any inju		21. Signature of Furieral Service License		22. Name and Address of Facility  THILL BLE NE	FUNERAL PIKE BALT	SERVICE M	P 21229
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one disease or condition resulting in death)	ons that caused the death. Do not er ause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	1	Approximate Interval Between Onset and Death
7,00	cate be executed obysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):				
.O. Box 68/60	ath certifii ttending p or use as	Physician/Medical	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delin Month	very Day Year
ecords, P	quires that the de n signed by the a uld be detached f	by	Part II. Other significant conditions contrib	uting to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	1	the cause of death?
r	The ate h	Completed				24a. Was an autopsy performed?	death?	topsy findings available completion of cause of
ion of Vital	ding Phya n. After this funeral di	atlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hosp  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ital: 1 Inpatient 2 ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time Injury	ent 3 DOA Other: 4 Nursing H	th (Check only one)  Mesidence  28d. Describe how inj		ify)
DIVISION	i Site	Certification:	a Could not be	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta		ral Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physici.	an: To the best of my knowledge, dea On the basis of examination and/or i and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	rred at the time, date ar	nd place, and due	to the cause(s)
	with To I	Z	29b. Signature and title of certifier	e MD	D 16354		v. 29	
	10		30. Name and address of person who comp	TAGNES 90	D16354 DO CATON AV	E BALT.	MD &	21229
	Sta Registr	1	31. Date filed (Month, Day, Year) NOV 3 0 2004	32. Régistrar's Signature	ppaks			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** THOMAS 4:22AM TOM 11 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CAPE ANN DRIVE Howard Columbia If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 X M 2 □ F OX Yrs. 489-34-151 Director MO Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event. Its Medical Examinar must be notified at HOWARD Director MD 1 ☐ Yes 2 No Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21046 US4 CADE ANN 10133 DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 1 Married 1 ☐ Yes 2 Ho Specify: Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. SECURITY SUPERVISOR 12th grade UNK and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental h Jesceener 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Importent: if Item 27 Is any Injury or other treu COLUMBIA MD 21046 Louise B. Thomas/ 10133 CAPE ANN DELVE timore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cometery, creatory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 12.02.04 ST. LOUIS, MISSOURI <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility VAUGHN C. GREENE FUNCRALSERVICES 21. Signature of Funeral Service Licenses 21229 au 5151 BALTIMORE, NATIONAL PIKE BALTIMORE, MP 23a. Part1. Enlarge disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Non Small Cell Lung Comon Immediate Cause (Final Physician METASTATIC 3 mouths disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Nes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan has 2 0 No 1 ☐ Yes 1 Tyes of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Natural Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number no wit 38500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sporks PATURENT Phy Koutrelaks 11065 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 3 0 2004 Registrar

			1- State of M Registrar	laryland / Depa <i>Cer</i>	irtment of H			2004	37753
			Decedent's Name (First, Middle, Last)		-		2. Date of Death		3. Time of Death
4	Physici /Medio		Han Fen Tang				November	Day Year 22 2004	11:34 PM
	Examir		4a. Facility Name (If not institution, give street and number	)	4b. City, Town, or	Location of Death		4c. County of Death	
			Saint Agnes Healthcare	- (1	Baltim	If Under 24 Hrs.			
	Funeral Director		5. Social Security Number 6. Sex 7. A 1 M 2 1 F 7. A	ge (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	ear) Cou	olace (State or Foreign ntry)
			Usual Residence of Decedent	09			0ct. 5,1	915	
	ryland how		10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	e Ma	cto	Maryland Baltimore	Cator	sville				1 ☐ Yes 2 🛣 No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cou	ntry?
	s 23s	rai	4820 Grand Bend Drive		21228			U.S.A.	· V
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 ie marked other then "naturel", or items 23a or 28e-f show or other treumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Deceden Armed Forces  1 ☐ Yes 2 ☒ If Yes, Give Year or Dates	] No	Vas Decedent of His Yes, specify Cubar ☐ Yes 2☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	etc.
20	72 ho	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupa	ition	16	b. Kind of Business/In	
2	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or	5+)	kind of work done d OO NOT use retired)	) )	ing		
2	led w lygier her th		5+	Prof	essor			Medicine	·
Maryland	12 should be filed within h and Mental Hygiene. 7 ie marked other then "; reumatic event, the Mes	Be	17. Father's Name (First, Middle, Last)  Tang Meiqiu			Xia Mu	ə (First, Middle, Mai	den Surname)	
Ž	d Men mark matic	10	19a. Informant's Name/Relationship (Type, Print)	10b Mailio	a Addrass (Street a			ity or Town, State, Zip	Code
Ma	th an		Yun Wang (Husband)					111e, MD 2	
ē,	thealth tem 27 i		20a. Method of Disposition	20b. Place of Dispos				c. Location - City or To	
E	Pages nent of It ant: If ite		1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	Balto./Wa			04 I.	aurel, Mar	·vland
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee	Wings Wi	Name and Address	s of Facility eral Home	of Cator	sville. Ti	
			23a Pant1. Enter the disease, or complications that cause shock, or hear failure. List only one cause on each						Approximate
	Pnysician		Immediate Cinal	onary Emb	*				Interval Between Onset and Death
	/Medical		resulting in death)	s a cons - luence of):	ראנווט				
	Examiner		Sequentially list conditions b. Africa	1 Fibrillati	on				
	pd tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury	s a consequence of):					
	ecute and I-trans	Examiner	that initiated events	s a consequence of):				_	
8760,	cate be executed physician and the burial-transit	alE	5 5 5 6 6 6 6 7	s a consequence on.					
687	es A t	edical	d.						
.O. Box	at the death certifi by the attending I tached for use as	Physician/Me		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
α.	that hed by deta	by Ph	Part II. Other significant conditions contributing to death	but not resulting in the un	derlying cause give	n in Part I.	23e. Did tobac	co use contribute to th	ne cause of death?
rds	w requires been sign should be						1 🗆 Yes	2 <b>□</b> √ 0 3 □ Prob	ably 4 Unknown
I Records,	The lar ate has page 2	Completed					24a. Was an autopsy performed	prior to cor death?	psy findings available inpletion of cause of
Vital	Physiclen: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?				(Check only one)		
of	Physi this c	၉	1 Yes 2 No Hospital: 1 Thipat			4 Nursing Ho		e 6 □Other (Specify	/)
n C		ion	27. Manner of Death 1	ury 28b. Time of Injury	28c. Injury Work	? _	28d. Describe how i	njury occurred	
Division	Attendideath.	icat	2 Accident investigation 3 Suicide 6 Could not be	ıjury - At home, farm, stre		es 2 □ No	28f Location (Stree	t and Number or Rura	I Bouto Number
ο	iel or Attendi s efter death. sl Director: A ed in by the fu	Certification;	4 Homicide determined 256. Place of in building, e	tc. (Specify)	ot, ractory, omco		City or Town, S		r Noble Wallibel,
	Hospit 4 hour Funer ely fille	edical C	29a. Certifier (Check only one)  (Check only one)	of examination and/or inv	occurred at the time estigation, in my opi	e, date and place, inion, death occurr	and due to the caus ed at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	. 10-011	29c. License		29d.	Date signed (Month,	Day, Year)
)	2)		DANJAY VINJAN	148577111	Pi	7495	No	vernber 23	3,2004
	9		30. Name and address of person who completed cause of Sankay Vinjamaram 9	death (Item 23a) (Type, F	rint)	Baitmore	MD ZI	2:29	
	Sta Registr	4	31. Date fled (Month, Day, Year) 32. Regist	rar's Signature	Spark				

TANG, HAN

State of Maryland / Department of Health and Mental Hygie ( ) [ ] 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 26, 2004 1:45 P. M THOMPSON ISABELLA BUCKINGHAM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. 2, 19 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1□M 2∏F 77 215-28-7398 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frama 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🔯 No Funeral Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2521 Ebony Road 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retirement Community 2 years Receptionist permit. Pages 1 and 2 should be file. Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry 2 Buckingham Hattie Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (husband) 2521 Ebony Road Baltimore, Maryland 21234 Richard D. Thompson, Sr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Woodlawn Cemetery 11-29-04 Woodlawn, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Vascular Accident Immediate Cause (Final **Physician** Cerebral Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1 ☐ Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a
To the Funeral E
completely filled i 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Klach DO061199 NOV 27 20041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 6601 N. Charles Street Baltimore, MD. Jason Black, M.D 31. Date filed (Month, Day, Year) NOV 3 0 2004 32. Registrar's Signature State Registrar

			1- State of Maryland / Department of Health and Mental Hygie 20 04 37755  Certificate of Death 8eg. No. 04	
	Dhysisi		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year  3. Time of Death	
	Physici /Medic		Joan R. Varholy November 26, 2004 5:05 A	VI
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  7	
			9507 Kings Croft Terrace, Unit P Perry Hall Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.   8. Date of Birth 9. Birthplace (State or Foreign	
в	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Marry Cand	μı
	ס		Usual Residence of Decedent	
	arylar show	J.	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit	
	tha M	ecto	Maryland Baltimore Perry Hall  10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	with Ba or	Funeral Director	10e. Street and Number  9507 Kings Croft Terrace, Unit P  10f. Zip Code  10g. Citizen of What Country?  U.S.A.	
	death ms 20	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,	_
9	after or Ita		Armed Forces?  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ No  1 □ Yes 2 ☑ No  1 □ Yes 2 ☑ No  Specify: White	
9	ural',	d by	Tear or Dates:	
꾸	in 72	iete	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry	
212	filad within 72 hours after death with tha Maryland Hyglene. sther than "natural", or Itams 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Parochial School	
פ	e filac al Hyg sothe	BeC	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
yla	rif. Pages 1 and 2 should be filad within 72 hours after death with tha Marylan satiment of Heatth and Mentai Hyglene. ortant: If item 27 is marked other than "natural", or itams 23a or 28a-1 show njury or other traumatic event, the Medical Examiner must be nutified at a.	To	Edward Riemer Naomi Ditchler	
Mar	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21128	
<u>ē</u>	Health tem 27 other tr		Mr. Thomas Varholy (husband) 9507 Kings Croft Terrace, Unit P, Perry Hall, MD  20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State	
<u>0</u>	Pages nent of I ant: If ite		1X Burial 2 Cremation 3 Removal from State cometery, crematory or other place) 4 Donation 5 Other (Specify)  Parkwood Cemetery  11/29/2004  Baltimore, Maryland	
Baltimore, Maryland 21215-0036	permit. Pages 1 and Dep. rtment of Health Important: If item 27 any njury or other tr once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Schimunek Funeral Homes	
<u> </u>	20 E E S		Some RineRer 9705 Belair Rd., Baltimore, MD 21236	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as calcular or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Cryst tree heart friction consequent	
ř.	/Medical Examiner		Due to (or as a consequence of):	
	9 = 1	er	Sequentially list conditions, a any, leading to immediate b. Due to (or as a consequence of).	
	outad Id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	
Ö,	e exection ar		resulting in death) Last Due to (or as a consequence of):	
8760	cartificate be executad Iding physician and Ise as the burial-transit	dlcal	d	
х 6	death cartific attending pl	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Вох	death in atten	iciar	In the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)	
0	that the de led by the a detached t	hys	9 ☐ Unknown 9 ☐ Unknown	
	Se ng		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?	
oro	w require bean sign should b	eted	1 Yes 2 No 3 Probably 4 Unknown	n 
Vital Records,	: The law cate has t	Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death?	Θ
g		e Co	1 Yes 2 No	
	yaician: s certific director,	To Be	25. Was case referred to medical examiner?  1   Yes   2   1	
0	ng Phya ter this neral dir		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
<u>S</u>	uttendin death. ctor: Af y the fur	satic	2 Accident investigation M 1 Yes 2 No	
Division of	Il or Attending P after death. Director: After t d in by the funera	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
_	Hospital 24 hours a Funeral I		29a. Certifier 1[Learnitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	To the Hospital or Attending Phyaician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	To the within 2 To the complet	X	29b. Signature and title of striffer 29c. License number 29d. Date signed (Month, Day, Year)	
•	11	1	D 58 465 November 29, 249	
1	0		30. Name and added it person who completed cause of death (Item 23a) (Type, Print)  Suescher Curch Mund hought	
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature	
	Registr		NOV 3 0 2004 Server & Sparter	

	Physic		1. Decedent's Name <i>(First, Middle, Las</i> Bobby Frank Van							2. Date of De Month	Day	Year	3. Time of Death 6:30am M
	/Medi Examii		4a. Facility Name (If not institution, give		)		4b. City, Town,	or Location	of Death	UCT.4	1,2004 4c. Co	unty of Deeth	
			Washington Adver		JILAI	nk.	Takoma			unl	FIC	ntgone	erv unk
**	Funeral Director	٠,	5. Social Security Number 6. Security Number 11	7. A	ge (In yrs. last b 64	irthday) Yrs.	Months Day		Min.	8. Date of Bir Month, Da May	<sup>1</sup> 2940	9. Birth	place (State or Foreign intry)
	D >		Usual Residence of Decedent  10a, State  10b, County		I too City To								
	Aaryla f shov	ō	DC 10a. State 10b. County		Washin								10d. Inside City Limits  XXYes 2 □ No
	r 28a-	Director	10e. Street and Number		Masiiiii	9 0011	10f. Zip Code				10g. Citizen	of What Cou	
	th with	alD	1730 7th St. NW	#808			2000	1			USA		
	ltems	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	13. W	as Decedent of Yes, specify Cu	Hispanic Or ban, Mexica	rigin? (Spe in, Puerto	cify Yes or No Rican, etc.)	)- 14.	Race - Ameri Black, White,	
036	ours after death with the Marylan rai', or items 23e or 28e-f show Examiner mast be motified at	Ď	1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 <b>(∑</b> If Yes, Give Year or Dates:	(NO	1	□Yes 21 No	Specify	:		Sp	ecity: Bla	ck
2-0	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show he Modical Even inter round be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a	(Give k	ent's Usual Occu	during mos	st of worki	na	16b. Kind	of Business/In	ndustry
121	within ene. than '	mpl	Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	o NOT use retir aybor	ed)					unk
id 2	filed Hygi Sther	Be Co	17. Father's Name (First, Middle, Last)				uj 20.	18. Moth	er's Name	(First, Middle,	, Maiden Sur	mame)	
ylar	should be nd Mental i marked c	To B	٥				unk	1					unk
Maryland 21215-0036	2 a a a		19a. Informant's Name/Relationship (7 Stephanie Dawki				Regenc						
	r Health Hem 27 other tr		20a. Method of Disposition		20b. Place of	of Dispos	ition (Name of	-		ate		on - City or To	
OE I	Page ent o nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Specify		Howar		atory or other pl	1	10/05	/2004	Washi	ngton.	חר
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Licens	iee		22 A	Name and Addi UStin R	ess of Facili	ity S Fun	onal Ho	mo	ing com,	DC
	00 2 4 Q	( V	23a. Part1. Enter the disease, or comp	libations that cause	846	3	821 14t	h Stre	et N	W Washi	ngton	DC 200	011
	Dhysisian	3 7	Immediate Cause (Final	one cause on each i	ine.			ing, such as	cardiac o	r respiratory ai	rest		Interval Between Onset and Death
	Physician /Medical	disease or condition resulting in death)  Respiratory Failure  Due to (or as a consequence of):										-	
	Examiner	Sequentially list conditions, if any, leading to immediate  Sequentially list conditions, Due to (or as a consequence of):											
	ted nsit												
Ć.	execuin and ial-train	if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):										-	
8760,	cate be executed physicien and the burial-transit	dical		d									
9	2 4	/Med	IF FEMALE:	23c. If yes, outcome	of programov								
Box	death certif a attending d for use a	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		2 Fetal death		etopic pregnant Other (specify)	у			23d.	Date of delive Month	ery Day Year
P.0	t the by th ache	hys	9 🗆 Unknown	9□ Unknown									·
	es be	by	Part II. Other significant conditions co	ntributing to death b	out not resulting i	in the und	derlying cause g	ven in Part I					he cause of death?
Records,	v requires been sign should be	Completed									res 2□No		pably 4 Unknown
Re	The law ate has b page 2 sl	ошо									rmed?	prior to con death?	psy findings available mpletion of cause of
Vital	(0	Be C	25. Was case referred to medical					26. Place	of Death	(Check only o	ne)	1 🗆 Yes	2 No
	S S	P	TE THE X NO	Hospital: X Inpatie		_	3 DOA		rsing Hon	e 5 ☐ Resid	dence 6 🗆	Other (Specify	y)
on (	ding F h. After funera	tlon:	27. Manner of Death  Natural 5 Pending  Accident investigation	28a. Date of Inju (Month, Da		Time of Injury		iry at ork? ]Yes 2 □	111	8d. Describe h	now injury oc	curred	
Division of	Attending or death. ector: Atterby the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Inj	jury - At home, fa	arm, stree				8f. Location (S	Street and Nu	ımber or Rura	Il Route Number,
Ö	ital or its after ral Dire	Cert	4 Fromede	Dusiding, et						City or Tow	m, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exem	sician: To the best iner: On the basis o and manner st	of examination ar	e, death ond/or inve	occurred at the testigation, in my	me, date an opinion, dea	id place, a ith occurre	nd due to the d d at the time, d	ause(s) and date and plac	manner as st	tated.  o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and manner st	a(60.		29c. Licen	se number			29d. Date sig	ned (Month,	Dey, Year)
)			Cife				367	57			Octobe	er 10,2	2004
			30. Name and address of person who c				•						
yé,	Sta	to	Dr. Cosette Jam 31. Date filed (Month, Day, Year)		06 Irvin	g St	reet N.	w. Was	hing	ton,DC	20010		
	Registi		NOV 3 0 2004	henera	1/4	1	no de l						

DHMH 17 Rev 1/2001

4, 6, 6, 5, 10d, 60, 0d

			1 - For Stete Registrar	State of Maryland / D	epartment of Health Certificate of Deatl		/ 1111 14	37757			
			Decedent's Name (First, Middle, Last			2. Date of D	eath	3. Time of Death			
	Physici /Medio		REGINALD M. VAN	NLANDINGHAM		Novemb	er 24 200				
	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location	n of Death	4c. County of De	eath			
		9	UNION MEMORIAL  5. Social Security Number 6. Se		BALTIMORE  hdav) If Under 1 Year I If Under	er 24 Hrs. 8. Date of B	N/A	Birthplace (State or Foreign			
н	Funeral Director			7574 0 -	rs. Months Days Hours	Min. (Month, L	lay, Year)	Country)			
	pu *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits			
	Maryla f sho	ō	MD. N/A		IMORE			1 ☐XYes 2 ☐ No			
	r 28a	rect	10e. Street and Number		10f. Zip Code		10g. Citizen of What	Country?			
	th with	ai D	228 N. MOUNT ST		21223		USA				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Modical Examination and injury or other traumatic event, it a Modical Examination and injury or other traumatic event, it a Modical Examination and injury or other traumatic event, it a Modical Examination in the notified at once.	by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ₹ No If Yes, Give △ Year or Dates:	13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica 1 Yes 2 No Specify	an, Puerto Rican, etc.)	14. Race - Ar Black, W Specify: B				
20	72 hou natura	eted	15. Decedent's Edu (Specify only highest grad	ucation 16a.	l Decedent's Usual Occupation (Give kind of work done during mo	set of working	16b. Kind of Busine	ss/Industry			
21215-0036	vithin 700.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	ist of working					
9	filed v Hygie other t		17. Father's Name (First, Middle, Last)	-]-	ACCOUNTANT 18. Moth	her's Name (First, Middl	ACCOUNT e, Maiden Surname)	ING			
a	lid be fental rked c	To Be	LEAK VANLANDING	SHAM	RU	JBY JOSEPH	Y JOSEPH				
Maryland	2 shou and h is ma	Γ.	19a. Informant's Name/Relationship (T)		ber or Rural Route Num						
	1 and Health sm 27 ther tr		RUBY VANLANDING  20a. Method of Disposition		28 N. MOUNT ST.  Disposition (Name of	BALTIMORE,					
Baltimore,	Pages ment of tant: If ite		1 Burial 2 Cremation 3 □F  4 Donation 5 □ Other (Specify)	Removal from State MT • ZIO	or, crematory or other place) ON CEMETERY	2-3-2004	BALTIMORE,	MARYLAND			
Ball	permit Depart Impor any in		21. Signatur Pheral Service Licens	*JONATHAN D. HIB	ER. Name and Address of Faci						
	Physician /Medical Examiner		23a. Party Enter the disease, or composingly, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. Do not not cause on each line.  a		s cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death  2 Weeks			
ļ,	po us	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence o	f):						
68760,	icate be executed physician and s the burial-transit	ai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence o	n):						
	tificate ig phys as the	ledicai		d							
.O. Box	The law requires that the death certificate has been signed by the attending trage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of d Month	elivery Day Year			
<u>a</u>	ires that the de signed by the a d be detached f	by	Part II. Other significant conditions co	ntributing to death but not resulting in	the underlying cause given in Part		tobacco use contribute	to the cause of death?  Probably 4 Unknown			
Records,	w require been si should b	iete				24a. Wa		autopsy findings available			
I Re		Completed				auto	opsy prior to death?	completion of cause of			
Vital	Physician: this certificatal director,	Be	25. Was case referred to medical examiner?	Hospital:	O++	e of Death (Check only					
ō	Phys ar this aral di	); To	1 ☐ Yes 2 ☐ No	28a. Date of Injury 28b. Ti	me of 28c. Injury at	lursing Home 5 Res	idence 6 Other (Sp how injury occurred	ecify)			
ion	ath. r: Afte	atior	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) In	jury Work? M 1 ☐ Yes 2 ☐	No					
Division of	al or Atte s after de l Directo d in by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fan building, etc. (Specify)	m, street, factory, office		(Street and Number or I wn, State)	Ru <i>ral R</i> ou <i>te Numbe</i> r,			
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After completely filled in by the funer.	Medicai C	29a. Certifier 1 Certifying Phy (Check only one)  1 Medical Exemi	sicien: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the time, date a /or investigation, in my opinion, de	nd place, and due to the ath occurred at the time	cause(s) and manner a , date and place, and du	as stated. ue to the cause(s)			
i	Mith To I	2	29b. Signature and title of certifier		29c. License number	6	29d. Date signed (Mor				
	B		30. Name an ddress p son o co	ompleted cause of death (Item 23a) (I		, Baltimak	= MD 21	218			
	Sta Regístr	_	31. Date filed ( <i>Month, Day, Year</i> )  NOV 3 0 2004	32. Registrar's Signature	,						
				7	South						

DHMH 17 Rev 1/2001

ORIGINAL

State Registrar person who completed cause of death (Item 23a) (Type, Print)

CA4

NOVEMBER 29,2004

Penn Street, Baltimore, Maryland 21201

			For State Registrar	Cei	artment of Health and rtificate of Death	rvientai mygie Reg.	2004	37759
	Physici	an.	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Marie Anna Waldhauser			November	27, 2004	8:45 P M
	Examin	er	4a. Fecility Name (If not institution, give street and number,		4b. City, Town, or Location of Deat	h	4c. County of Death	
*	Funeral	34,	Manor Care Nursing Center- 5. Social Security Number 6. Sex 7. A	Je (In yrs. last birthday)	Towson If Under 1 Year If Under 24 Hrs		Baltimor	
ħ	Director	Ñ	215-07-2637 1□ M 21XF	87 Yrs.	Months Days Hours Min.	Jan. 15.	1917 Mar	lace (State or Foreign htry) .ULand
	pun *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			0d. Inside City Limits
	Maryli f sho	ō	Maryland Baltimore		Baltimore			1 ☐ Yes 2 TYNo
	the l	rect	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cour	
	h with	al Di	9010 Transoms Road		21236		U.S.A.	.,
	ems a	Funeral Director	11. Marital Status 12. Was Decedent Armed Forces	Ever in U.S. 13. V	Was Decedent of Hispanic Origin? (Sf Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Americ Black, White,	an Indian,
36	72 hours after death with the Maryland neturel', or Items 23g or 28a-f show Jical Evarrinet must be notitied at	by Fu	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ If Yes, Give	No	I □ Yes 2 No Specify:	,	Ci4	
21215-0036	Phour	ed b	15. Decedent's Education	16a, Deced	lent's Usual Occupation	166	. Kind of Business/Inc	
215	within 72 ene. than "ne	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	(Give	kind of work done during most of wo DO NOT use retired)	rking	. Rang of businessymm	lustry
21	e filed within at Hygiene. other than '	Com	8th Grade	Cler	ical Worker		Radio Comp	any
Maryland	be fill ntal Hy od oth even	Be	17. Father's Name (First, Middle, Last)  Joseph Waldhauser			me (First, Middle, Maid	len Sumame)	
3	should be nd Mental marked o	J.	Joseph Waldhauser  19a. Informant's Name/Relationship (Type, Print)	10h Mailia	Anna g Address (Street and Number or Ri	McEntee	T . O . T	
<u>S</u>	d 2 th a tree tree		Mrs. Jeanne Wenger (niec		Transoms Road, B			Code)
re,	of Hea		20a. Method of Disposition	20b. Place of Dispos	sition (Name of natory or other place)		Location - City or To	wn, State
<u>m</u>	Page:		1 □XBurial 2 □ Cremation 3 □ Removal from State  • 4 □ Donation 5 □ Other (Specify)	Most Holy		2/2004 Bal	Ctimore. M	aryland
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other		21. Signature of Funeral Service Lice (see		. Name and Address of Facility Sc.	himunek Fu	reral Home	\$
_	707 g ol		23a. Part1. Enter the disease, or complications that cause	1	9705 Belair Rd.,	Baltimore,	, MD 21236	
	F-5000000		shock, or heart failure. List only one cause on each I	ina	r the mode of Twi g, such as cardia	or respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a consequence of):	e may	Conc	0/	Year!
1	Examiner			a consequence or):	17. A. T.		58.0	1
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence of):				
	ecuted and trans	Examiner	that initiated events C.					
60,	icate be executed physician and s the burial-transit	al E	Due to (or as	a consequence of):				
68760,	ficate physis the	edical	d					
Вох	that the death certii ed by the attending detached for use a		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome				23d. Date of delive	ry
	deatl	sicia	in the past 12 months?  1 Yes 2 No 4 Pregnant a		Ectopic pregnancy Other (specify)		Month	Day Year
P.O.	d by the	Physician/M	9 Unknown				7,112	
	ngi be	by	Part II. Other significant conditions contributing to death t	out not resulting in the un	iderlying cause given in Part I.	23e. Did tobaco	o use contribute to th	
~	B C N					1 🗆 Vaa	2 □ No. 2 □ Brob	
Ö	v re bed sho	etec					2 No 3 Prob	ably 42 doknown
Recol	he taw re e has bee tge 2 sho	ompieted				24a. Was an autopsy	24b. Were autop	ably 4 Sknown  Day findings available apletion of cause of
tal Recor	The tarate has	e Completed	25. Was case referred to medical		26 Plans of Das	24a. Was an autopsy performed 1 □ Yes 2 ☑	24b. Were autop	ably 42 doknown
f Vital Records,		o Be	25. Was case referred to medical examiner?  1  Yes  No  Hospital: 1   Inpati	ent 2 □ ER/Outpatient	Other	24a. Was an autopsy performed 1 Yes 2 3	24b. Were autoprior to condeath?	ably 4 Anknown  by findings available apletion of cause of 2 PNo.
		To Be	examiner? 1   Yes 20 No	ry 28b. Time of	Other	24a. Was an autopsy performed 1 □ Yes 2 ☑	24b. Were autoprior to cordeath? No 1 Yes	ably 4 Anknown  by findings available apletion of cause of 2 PNo.
	tending Physician: leath. tor: After this certifics the funeral director, t	To Be	examiner?  1  Yes 20 No	rry 28b. Time of Injury	Other: 4 Vursing H	24a. Was an autopsy performer 1 Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	24b. Were autoprior to cordeath? 1 Yes  6 Other (Specify jury occurred	ably 4. Stocknown  osy findings available opletion of cause of 2. Who.
	or Attending Physician: after death. Director: After this certifica in by the funeral director, g	To Be	examiner?  1  Yes 20 No	ry 28b. Time of	Other: 4 Vursing H	24a. Was an autopsy performer 1 Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	24b. Were autopyrior to cordeath? 1 Yes  6 Other (Specifyjury occurred	ably 4. Stocknown  osy findings available opletion of cause of 2. Who.
Division of Vital Recor	or Attending Physician: after death. Director: After this certifica in by the funeral director, g	Certification: To Be	examiner?  1 Yes 2 No  Hospital: 1 Inpation  27. Manner of Death  1 Natural 5 Pending (Month, Date of Injugation)  2 Accident investigation  3 Suicide 6 Could not be determined  4 Homicide  28e. Place of Injugation  28e. Place of Injugation  29e. Certifier 1 Sertifying Physician: To the Sest	28b. Time of Injury  At home, farm, stre  (Specify)	Other: 4 Uursing H 28c. Injury at Work? M 1 Yes 2 No et, factory, office	24a. Was an autopsy performer 1 Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	24b. Were autoprior to cordeath? 1   Yes  6   Other (Specify jury occurred  and Number or Rural ate)	ably 4. Anknown  osy findings available opletion of cause of 2. Pro.  Route Number,
	Hospitel or Attending Physician: 24 hours after death. Funerel Director: After this certifica stely filled in by the funeral director.	edical Certification: To Be	examiner?  1 Yes No  1 No Pending (Month, Dal Accident 3 Suicide 4 Homicide)  1 No Pending (Month, Dal Accident 3 Suicide 4 Homicide)  1 No Pending (Month, Dal Accident 3 Suicide 4 Homicide)  1 No Pending (Month, Dal Accident 5 Suicide 4 Homicide)  28a. Date of Inju (Month, Dal Accident 5 Suicide 4 Homicide)  28b. Place of Inju (Month, Dal Accident 5 Suicide)	28b. Time of Injury  Lary At home, farm, stre  (Specify)  my knowledge, death examination and/or inv	Other: 4 Uursing H 28c. Injury at Work? M 1 Yes 2 No et, factory, office	24a. Was an autopsy performer 1 Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	24b. Were autoprior to cordeath? 1   Yes  6   Other (Specify jury occurred  and Number or Rural ate)	ably 4. Anknown  osy findings available opletion of cause of 2. Pro.  Route Number,
	or Attending Physician: after death. Director: After this certifica in by the funeral director, p	Certification: To Be	examiner?  1 Yes No  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Inju. (Month, Date of Inju.) (Month, Date of Inju.) (Month, Date of Inju.) (Month, Date of Inju.) (Month, Date of Inju.) (Secretifier (Check only)  29a. Certifier (Check only)  29a. Medical Examiner: On/the basis of Inju.)	28b. Time of Injury  Lary At home, farm, stre  (Specify)  my knowledge, death examination and/or inv	Other: 4 Uursing H 28c. Injury at Work? M 1 Yes 2 No et, factory, office	24a. Was an autopsy performer 1 Yes 2 1 1 2 1 2 2 3 2 3 2 3 2 3 2 3 2 3 2 3	24b. Were autoprior to cordeath? 1   Yes  6   Other (Specify jury occurred  and Number or Rural ate)	ably 4. Anknown  osy findings available opletion of cause of 2. Anko.  Another Number,  ated. the cause(s)
	Hospitel or Attending Physician: 24 hours after death. Funerel Director: After this certifica stely filled in by the funeral director.	edical Certification: To Be	examiner?  1 Yes No  27. Manner of Death  1 Accident  3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  1 Pospital: 28a. Date of Inju. (Month, Date of Inju.) (Mon	28b. Time of Injury  Large At home, farm, stree (Specify)  To my knowledge, death examination and/or invested.	Other: 4 Nursing H 28c. Injury at Work? M 1 Yes 2 No et, factory, office  Occurred at the time, date and place estigation, in my opinion, death occurred to the control of	24a. Was an autopsy performer 1 Yes 2 1 1 2 1 2 2 3 2 3 2 3 2 3 2 3 2 3 2 3	24b. Were autoprior to cordeath? 1 Yes  6 Other (Specify jury occurred  and Number or Rural ate)  (s) and manner as strind place, and due to	ably 4. Anknown  osy findings available opletion of cause of 2. Anko.  Another Number,  ated. the cause(s)
	Hospitel or Attending Physician: 24 hours after death. Funerel Director: After this certifica stely filled in by the funeral director.	edical Certification: To Be	examiner?  1 Yes No Hospital: 1 Inpating 27. Manner of Death 1 Accident 3 Suicide A Homicide	28b. Time of Injury  Lary At home, farm, stre  (Specify)  The my knowledge, death as a mination and/or investigation Other: 4 Nursing H 28c. Injury at Work? M 1 Yes 2 No eet, factory, office  Occurred at the time, date and place estigation, in my opinion, death occurred to the street of the street occurred at the time, date and place estigation, in my opinion, death occurred to the street occurred at the time, date and place estigation, in my opinion, death occurred to the street	24a. Was an autopsy performed 1 Yes 2 1 1 Yes 2 1 2 1 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3	24b. Were autoprior to cordeath? 1 Yes  6 Other (Specify jury occurred  and Number or Rural ate)  (s) and manner as strind place, and due to	ably 4. Anknown  osy findings available opletion of cause of 2. Anko.  Another Number,  ated. the cause(s)	
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DHMH 17 Rev 1/2001

_	ian	Decedent's Name (First, Middle  Delegation	, Last)		1 - 1-	artment of I C339, 1-1 rtilicate of		2.	Date of Death Month Vember	h		3. Time of Death	
/Medi	cal	Robert 4a. Facility Name (If not institution)	airo etropt and pur		lsh	4h Cihi Toum o	or Logation of		velloer		2004 inty of Death	01:42 A	
Examir	ner	7640 Dunman Way		iber)		4b. City, Town, o		Deam				County	
Funeral Director		5. Social Security Number 216–90–5797	6. Sex 11X1 M 2□F	7. Age (In yrs. la	ast birthday) 29 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,	Year) ,1975	9. Birthp Coun MD		
M. T	1	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation					1	0d. Inside City Limi	
-f show lied at	to	MD Balt	imore		Dunda	ılk						1 □ Yes 2 🕅 1	
or 28e	Oirec	10e. Street and Number				10f. Zip Code			10	0g. Citizen	of What Coun	try?	
s 23a	rai	7640 Dunmanway	140 111 1 1 1 1			212			USA Specify Yes or No- 14. Race - American Indian,				
"natural", or items 23a or 28e-f shov edical Examinar must be natified at	by Funeral Director	11. Marital Status  1   Never Married 2   Marri 3   Widowed 4   Divorced	Armed For	2 <b>X</b> No		Was Decedent of Hif Yes, specify Cubin 1 ☐ Yes 2X No	an, Mexican,  Specify:	Puerto Rica	Yes or No- in, etc.)	E	Race - Ameno Black, White, Cify: Whi	etc.	
natura lical E	sted	15. Decedent (Specify only highes	's Education		16a. Dece	dent's Usual Occup	nation	of working			f Business/Inc		
r then "natur	Completed	Elementary/Secondary (0-12)	College (1-	-4or 5+)	life.	DO NOT use retire	d)	or working					
d other t		12 years 17. Father's Name (First, Middle, I	Last)		Dry	waller	18. Mother	's Name (Fi		Construction  Aiddle, Maiden Surname)			
and Mental s marked o umetic eve	To Be	Robert W. Welsh	Jr.						Mc Hugh				
- E		19a. Informant's Name/Relationship (Type, Print)  Robert W. Welsh Jr. Father  5 Corns Drive, Bel								•	wn, State, Zip	Code)	
of Health litem 27   r other tre		20a. Method of Disposition	2	20b. Pla		osition (Name of matory or other place		Date ecembe	- 2		n - City or To	wn, State	
merit tent: If		Marial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		Oak		Cemetery		1, 200		Dunda:	lk,MD.		
Department of Healt Importent: If item 2; any injury or other tonce.		21. Signature of Funeral Service L	Licensee	nelle	y 200	Name and Address onnelly In 110 Solle	ss of Facility Tunera ers Po	l Home	e Of Di	undall undall	k,P.A. k,MD. 2	21222	
		23a. Part1. Enter the disease, of shock, or heart failure. Use	complications that ca only one cause on ea	aused the death ach line.	Do not ent	er the mode of dyin	ng, such as ca	ardiac or res	spiratory arre	est,		Approximate Interval Between Onset and Death	
ysician		Immediate Cause (Final disease or condition	Mamaat	Immediate Cause (Final									
Medical		resulting in death)	a Narcol	ic Into	xicat	ion						Oliset and Death	
aminer		resulting in death)		or as a consequent		ion						Onset and Death	
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	Dharaisi		1. Decedent's Name (First, Middle, Last)	1				2.	Date of Death		V	3. Time of Death
	Physici /Medic		Joann Wa	tson					Month V	Day 9 6	Year	0856 AM
	Examin		4a. Facility Name (If not institution, give s	Maryland med	ical	4b. City, Town, o	r Location of	f Death		4c. County o	f Death	
	Funeral		Social Security Number     6. Sex		ast birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. Min.	Date of Birth (Month, Day,	Year	9. Birthpl Count	lace (State or Foreign
	Director		214-00-0233	M 2 XF 43	Yrs.	World S Days	110013	J.	AN 19,	1961	Mar	yland
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation					10	Od. Inside City Limits
	daryl f sho	ច់	Marriand Harrana				1					1 □ Yes 2 X No
	the 28a	Director	Maryland Howard			Elkri	uge		10	g. Citizen of W	hat Coun	tov?
	3a or		6506 Deep Run	Parkway		2107	5				SA	, .
	death	Funeral		12. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of H		gin? (Specify	y Yes or No-	14. Race		an Indian,
21215-0036	d within 72 hours after death with the Maryland Jene. r than "natural", or Hema 23a or 28a-f show The Madical Evant ment be Indiffed at	by	1 ☐ Never Married 2(X) Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		fYes, specify Cuba I□Yes 2□XNo	n, Mexican, Specify:	, Puerto Ric	an, etc.)	Specify:	, White, e	
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215	- 3	Jple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done of NOT use retired	during most 1)	of working				
7	filed within the Hygiene. other than rent, the M	Con	12		Del:	i Clerk				Grocer	y St	ore
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Baltimore,	그는 분수		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Liceped</li></ul>			natory, I				Balti		e, MD
B	permi Depa Impo any ir		Molumes All	sall	Ci	Name and Address	n Soc	iety	of MI	), Inc		01000
			23a, Part 1. Enter the disease, or compli	regorchik cations that caused the death.	. Do not ente	99 Fred 6 or the mode of dyin	g, such as c	ROA:	G_Balt spiratory arres	imore	,	Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.	11.	. / 00		0	1	•		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseque	ence of):	jero jes		_ \	in the		-	
	Examiner		Sequentially list conditions	. Unelate	ed =	ten a	ll l	rous	plan	go HOM		
	sit s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ence of):			1				
	and I-tran	Examin	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):							
8760,	cate be executed physician and the burial-transit	alE			31.00 0.7.							
687	fficate g phys	edical										
Вох	death certifi e attending id for use as	N/M	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnan		w. 1				23d. Date	of deliver	У
.O. B	that the death certifi ed by the attending detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of dea		Ectopic pregnancy Other (specify)				Mont	n [	Day Year
Ρ.	d by the	Phy	9 Unknown Part II. Other significant conditions con		bi i- 16		in Deat		00- 0:44-			
Vital Records,	es pe	d by	Faith, Other signmeant conditions con	thibuting to death but not resul	inig in the un	denying cause give	en manti.					e cause of death?
00	w requir been s should	Completed						_	24a. Was an	24h W	ere auton	sy findings available
Re	The lav	шо					-	_	autopsy performe	id? de	or to com ath?	pletion of cause of
ita		0	25. Was case referred to medical				26. Place of	of Death (C	14 Yes 2 L	] No   1 [	Yes 2	No No
	ly di	To B	examiner? 1 ☐ Yes 2 No	lospital: 1 npatient 2 E	R/Outpatient	3 DOA Othe	ar			ce 6 □Other	(Specify)	
n of	ding Pt		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	at	28d.	Describe how	injury occurred	1	
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□N					
Division	al or Attendate after death after death Director: d in by the	Certification:	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)		et, factory, office		28f.	City or Town,	et and Number State)	or Rural	Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)	sician: To the best of my knowner: On the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the timestigation, in my op	ne, date and pinion, death	place, and occurred a	due to the causet the time, date	se(s) and manr and place, an	ier as sta d due to t	ted. the cause(s)
	omply	Me	29b. Signature and title of certifier			29c. License	number		29d	. Date signed (	Month, D	ay, Year)
)	- > - 0		AB du	3-		Dr	24)	159	3	11/19	154	į.
,	0		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, F	Print)	0-12			1	·	
	10		Ashra	Kachos.	22	S. Gree	ne St	treet	Bal	timore	, M1	D 21201
	Sta Registr		31. Date filed (Month, Day, Yeal) NOV 3 0 2	32. Registrar's Signatu	ure &	Span	KN					
			114100	/		* *						

			1 - For Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F		l Mental Hy	giene	11. 37762
	Physic	ian	1. Decedent's Name (First, Middle, John Elwood Wej					2. Date of De Month	Day	Year
	/Medi Examir		4a. Facility Name (If not institution,			4b. City, Town, o	r Location of De	ath	4c. County	1004 5:15 PM of Death
			FRANKlin Squ	LARE HOSY	DITAL	Ros If Under 1 Year	e clA/e	-	BAL	TIMORE
	Funeral Director		5. Social Security Number 213–10–7910	1. Sex 7. Age 1. M 2□ F	(In yrs. last birthday) 87 Yrs.	Months Days	Hours Mi		917	Birthplace (State or Foreign Country)     MD
	and *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Li	ocation	1			10d. Inside City Limits
	Manyla	tor	MD Balti	more	Rosedale					1 ☐ Yes 2X No
	or 28a	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	eath w	erai	8234 Phildelph		ever in U.S. 13	212 Was Decedent of H		(Specify Ves or N	USA	- American Indian,
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, if a Medical Exemitier must be notified at 2006.	þ	1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces?  1 Xes 2 N If Yes, Give 0 Year or Dates 1	71945	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	Specify:	erto Rican, etc.)		White etc.
215-0036	72 hor	eted	15. Decedent's (Specify only highest	Education	16a, Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of w	rorking	16b. Kind of Bu	siness/Industry
2121	within iene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+1 1	<i>DO NOT</i> use retired Engineer	3)		Engine	ering
	be filed ital Hygi of other	Be C	17. Father's Name (First, Middle, La				18. Mother's N	ame (First, Middle	, Maiden Sumam	э)
Maryland	should to marked to marked umatic	To Be	William Jacob W  19a. Informant's Name/Relationship		10b Maili	ng Address (Street	Mabel	(unknow	-	Charles Tim Condail
	and 2 sl salth an n 27 ls r		John Weitzel/So		1	1 Forge R		e Marsh	MD 2116	
Baltimore,	Pages 1 a nent of He- int: If item iry or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from State		matory or other place		Date		City or Town, State
Itim	it. Pag triment ortant: njury o		' 4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lie	cify)	Moreland			/29/2004		
Ba	permit. Departr Imports any inju		) Q	Cots	1.	211 Chesa	.co Ave	vach/Rose Baltimon	edale Fur re MD 212	neral Home 237
			23a. Part1. Enter the disease, or conshock, or heart failure. List or immediate Cause (Final	omplications that caused aly one cause on each line	e.		,	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. A 5 p / R 4	consequence of):	len Mol	114			1 Week
	Examiner	_	Sequentially list conditions, if any, leading to immediate	b						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		consequence of):					
,00	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
68760,	ate hy:	dica		d						
Вох	death certifica attending phase as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of		Ectopic pregnancy			23d. Date	of delivery th Day Year
o.	that the dea ed by the at detached fo	ıysici	1 Yes 2 No	4□ Pregnant at t 9□ Unknown	ime of death 5	Other (specify)			Mori	th Day Year
rds, P.	og og	by	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did t	_	bute to the cause of death?  3 Probably 4 Unknown
Records,	e law requir has been si je 2 should	Completed						24a. Was		ere autopsy findings available for to completion of cause of
al B								perfo	rmed? de	eath? □Yes 2□No
Vital	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 Anpatien	nt 2 ER/Outpatier	nt 3 DQA Othe	200	eath (Check only only only only only only only only		r (Specific)
n of	ding Phy h. After this funeral c		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day			at		how injury occurre	
Division	ttendii death. ctor: A / the fu	icati	2 Accident investigat	be as Bloom of Injur	ry - At home, farm, str		Yes 2 □ No	28f Location (	Street and Numbe	r or Rural Route Number.
Div	pital or Atteno ours after deat leral Director: filled in by the	Certification:	4 Homicide determine	building, etc.	(Specify)	eet, ractory, ornice		City or To	vn, State)	or ribrar route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifier Check only 2 Medical Ex	Physician: To the best of aminar: On the basis of and manner stat	examination and/or in-	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	Tot withi Tot	×	29b. Signature and his of certifier	1	10	29c. License			,	(Month, Day, Year)
7	. (	-	30. Name and address of person wh	o completed cause of de	ath (Item 23a) (Type		502		11/26	
_	12		Jane				Frankli	n Square	Dr. B	altimore MD
	Sta Registr	_	31. Date filed (Month, Day, Year)  NU v 3 0 ZUÜ4	32. Registral	r's Signature	V			)	

John WeiTzel

Amend Please Type or Print in Black Indelible Ink, Fnsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier () () 37763 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Gorman Edward Whittle 3:45 PM 23 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEUARE 7. BAL If Under 24 Hrs. Ko.se HOSPILA LIMORE 5. Social Security Number If Under 7. Age (In yrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1X M 2□F Hours Min. 219-10-6259 78 **Director** Nov. 6,1926 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 No Maryland Baltimore Dundalk Essex Street and Number 620 Kelso 10f. Zip Code 10g. Citizen of What Country? Drive Apt. C 201 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married ō 21215-0036 1 ☐ Yes 2 No Specify: þ 3 → Widowed 4 □ Divorced "natural', White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic avent. Ite Medic 2002. Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry 10 Years Expeditor Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Arthur Whittle Dorothy Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Denise Spurrier/Niece 1949 Codd Ave. Dundalk, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland ■ Donation 5 ☐ Other (Specify) Gardens of Faith Cem 11/29/2004 21. Signature of Funeral Service License 22. Name and Address of Facility Property Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HypcxIA Du to (or as a consequence of): /Medical Examiner HE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a con Suence of): RENAL Disease Box 68760. attending physician Completed by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) \_ 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? (es 2.2.No certificate 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 npatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ٩ funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending Injury death. investigation Il Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated the 29b. Signature and title of certifier 29c. License number D55306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKlin RE DR. BAITIMORE Md 9000 DENNIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 3 0 2004

Registrar

Deposed in New York Medical Case   Security Williams   Security				1 - For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of H	lealth and N Death		200 g. No.	4 3	17764
Second large of the control of the	٢	Physici	an	347	,	_			Month	Day		
TRINGED TO COLOR DE L'ANDIGE D				Helen Betty W  4a. Facility Name (If not institution, gir	iley ve street and numbe	er)	4b. City, Town, or	r Location of Death				2.01 1
163-12-7034   Control				FRANKLIN SQUARE	- HOSPITA	L CENTER	ROSEDI	ALE		-		RE
10.5   1.2   7.5			Г			V			8. Date of Birth (Month, Day,	Year)	9. Birthpl Coun	ace (State or Foreign
The part of the pa				163-12-7834	25.	87 Yrs.			Nov. 19,	1917	Penn	sylvania
The part of the pa		ryland how		10a. State 10b. County		10c. City, Town or Lo	ocation				10	Od. Inside City Limits
The part of the pa		88-18	ctor		d	Bel Air						1 ☐ Yes 🏂 📆 No
The part of the pa		with the							10			try?
The part of the pa		ns 23	erai			nt Ever in U.S. 13.			ecify Yes or No-			an Indian
The part of the pa	9	after or Iter	Fun		Armed Force	s? ≩No	If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)			
The part of the pa	9	ural',	d by	3 ₩idowed 4 Divorced	Year or Date:	s:	1 □ Yes 2 No	Specify:		Specifi	y: 	White
The part of the pa	<u>-</u> 2	n 72 t	iete	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	kind of work done of	during most of work	ing 16	6b. Kind of B	usiness/Ind	ustry
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Part   Emiliary   State   Part   Emiliary   State   Part   Emiliary   State   Part   Emiliary   State   Part   Emiliary   State   Part   Emiliary   State   Part   Emiliary   State   Part   Emiliary   State   Part   State   Part   State   Part   State   Part   State   Part	a E	mit. F Dartm Dortar / injur		11/1/						LOWSOII	, PEL	yrana
23. Date of delivery from the course of the	<u> </u>	Pe di la		17 H	Al-		L317 Cokes	sbury Roa	ale, P.A. d, Abing	don, M	arvla	nd 21009
Section   Sect	- September	/Medical Examiner	niner	/ shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions	a. PNEU	MONIA as a consequence of):	er the mode of dying	g, such as cardiac	or respiratory arres	t,		Interval Between
VALVILAR HEART DISEASE ATRIAL FIBRILLATION,    1	9	rtificate be execung physician and as the burial-tra	dicai	resulting in death) Last	cDue to (or a	as a consequence of):						
VALVILAR HEART DISEASE ATRIAL FIBRILLATION,    1		the death ce y the attendia ached for use	nysician/N	23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	1 □Live birth 4□ Pregnant	2 Fetal death 3 at time of death 5						,
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  1 Natural  28. Place of Death (Check only one)  27. Manner of Death  1 Natural  28. Place of Death (Check only one)  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Death (Check only one)  28. Date of Injury  28. Date of Death (Check only)  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Death (Check only)  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  29. Dat		s that gned b	y Pl	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use conti	ribute to the	cause of death?
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  1 Natural  28. Place of Death (Check only one)  27. Manner of Death  1 Natural  28. Place of Death (Check only one)  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Death (Check only one)  28. Date of Injury  28. Date of Death (Check only)  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Death (Check only)  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  28. Date of Injury  29. Dat	gi	equire sen sig ould b	ted l	VALVULAR HEA	RT DISEA	SE , ATRIA	L FIBRIL	LATION,	1 🕱 Yes	2 🗌 No	3 🗌 Proba	bly 4 □Unknown
State   Stat	II Reco	: The law r cate has be page 2 sh	Comple	COPD.					autopsy performe	d? c	leath?	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. WASSIM EL-HITTI, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	Ž	sician certifi rector	0	examiner?	Hospital:		Othe					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. WASSIM EL-HITTI, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	Ö	Phys or this oral di	<b>-</b>		28a. Date of In	jury 28b. Time of	IL SELDON	4   Nursing Ho				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. WASSIM EL-HITTI, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	0	ath. r: Afte	atio			Day Year) Injury	Work	(?				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. WASSIM EL-HITTI, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	DIVIS	tal or Atta rs after dei al Diracto ed in by th	Certific	dataminad	286. Place of I	njury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, office		28f. Location (Stree City or Town, S	et and Numbe State)	er or Rural i	Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. WASSIM EL-HITTI, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature		tha Hospi nin 24 hour the Funar.									and due to t	he cause(s)
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		10						DE ADIVA	= 1221 +	4000	MI	21225
		Sta	te	31. Date filed (Month, Day, Year)	32. Regis		WIT SKUPTI	NC UNIVE	DALIN	1014C	110	/

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryland /	Depa		Health and		_	37765
	Physic /Medi		Decedent's Name (First, Middle, Last)  Jessie Wanda	Zamerski		II.		2. Date of Death Month November	Day Year	3. Time of Death 4 2355 M
	Examir		4a. Facility Name (If not institution, give st			4b. City, Town,			4c. County of Deat	h
			Upper Chesapeake N 5. Social Security Number 6. Sex	fedical Center 7. Age (In yrs. last b	inthday)	Be If Under 1 Year	1 Air	Irs. 8. Date of Birth	Harfo	
	Funeral Director			M 2∏F 82	Yrs.	Months Days		lin. (Month, Day, ) June 17,	Year) 1922	nplace (State or Foreign untry) Maryland
	Maryland	tor	10a. State 10b. County  Maryland Harfor	10c. City, To		el Air				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 282	Director	10e. Street and Number	···		10f. Zip Code		100	g. Citizen of What Co	untry?
	s 23a	ral	1106 Timberlea Driv				21014		U.S.	
36	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or items 23a or 28a-1 show event, it is Medical Examinar must be routified at	y Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give	i	Vas Decedent of l Yes, specify Cub ☐ Yes 2∏ No		(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White Specify:	
9	2 hour	ted t	15. Decedent's Educa	Year or Dates:	a. Decede	ent's Usual Occu	pation	16	6b. Kind of Business/	White
21215-0036	ithin 7 ie. ien "n	Completed by	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give k life. D	rind of work done O NOT use retire	during most of during	working		
	e filed within al Hygiene. other than " vent, Itte Me		8th Grade 17. Father's Name (First, Middle, Last)			Wrapper	10 Mark and 1	In the Adiabatic	Food Sto	re
land	ould be f Mental P arked of atic eve	To Be	Roman Swiderski					<sub>lame (First, Middle, Ma</sub> ksandra Koʻ		
Maryland	S DE E	-	19a. Informant's Name/Relationship (Type	a, Print) 19	b. Mailing	Address (Street		Rural Route Number, (	·	ip Code)
	1 and 2 Health a em 27 is		Theodore Zamerski					Bel Air, Ma	aryland 21	014
Jore			20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Re	moval from State 20b. Place cemet	of Dispos ery, crem	ition (Name of atory or other pla			oc. Location - City or	
Baltimore,	4 t # 7		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service (Licentee		-	slaus	12/	02/2004 B	altimore,	Maryland
Ba	Depa Impo any ir		B. D.					chimunek Fi hail Rd., 1		e of Bel Ai
	Physician /Medical Examiner pnuisi-Iransii	Examiner	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cause on each line.	e of):			er Accid		Approximate Interval Between Onset and Death
P.O. Box 68760,	death certificate e attending phys d for use as the	Physician/Medical E	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	b. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetaf death 4 □ Pregnant at time of death 9 □ Unknown	h 3□6	Ectopic pregnanc Other (specify)	у		23d. Date of deli Month	very Day Year
	quires tha n signed uld be del	by	Chronic Atria	Fibrillat		derlying cause giv	ven in Part I.		cco use contribute to	
Vital Records,	The law requires that the tee bas been signed by the sage 2 should be detache	Completed	Hypertension Coronary Arter	y Disease				24a. Was an autopsy performe	prior to o	opsy findings available ompletion of cause of
/ita	ysician: The is certificate h director, page	BeC	25. Was case referred to medical	<i>'</i>				eath (Check only one)	12 163	93,110
of	Attending Physician: r death. ector: After this certifici y the funeral director.	. To	1 Yes 2 No Ho.		utpatient Time of	3 □ DOA Ott	4   Nursing	Home 5 Residence		fy)
lon	nding Phy th. : After thi e funeral	atlon	1 Natural 5 Pending 2 Accident investigation		Injury	28c. Inju	yat k? Yes 2 □ No	28d. Describe how	injury occurred	
Division	of or Attendiate after death Director: A din by the fi	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, stree			28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Physic 2 Medical Examine	cian: To the best of my knowledger: On the basis of examination and manner stated.	e, death ond/or inve	occurred at the till estigation, in my o	me, date and pla pinion, death oc	ce, and due to the caus curred at the time, date	se(s) and manner as	stated. o the cause(s)
	withi To th	3	29b. Signature and title of pertifier			29c. Licens	e number	29d	. Date signed (Month)	Day, Year)
ĺ	X	1	· orn	(20	)	H 5	5922	N	ovemberz	3004
	Sta Registr		Anthony W: Sam 31. Date filed (Mnth, Day, Year)  NOV 3 0 2004	pleted cause of Sath (Item 23a)  2. R gistrar's Signatur	(Type, P	o Upper	Chesa	peake Dr	ive Bel Ai	n, MD21014

11/28/04

Zamerski, Jessie

			1 - For Stata Registrar	State of I	Maryland / D		ment of			and M		giene		L	377	66
	Physic	ian	1. Decedent's Name (First, Middle, La	ast)							2. Date of Dea Month			rear	3. Time of D	eath
	/Medi	cal	Erma L. Zorn  4a. Facility Name (If not institution, gir	a street and number	(a)	45	- City Tay	1			Novembe		3, 20	04	1:15	Р
	Examir	ner	311 Harlem Lane	ve street and numbe	")		b. City, Tow atons:			or Death		4c.	County of			
	Funeral		5. Social Security Number 6.		Age (In yrs. last birth	fay) If	Under 1 Ye	ear 📗	If Under		8. Date of Birth	n , ,	Balt	9. Birtho	ace (State or F	Foreign
	Director		213 00-3030	1□M 2⊠F	88 Y	s.	lonths Da	iys	Hours	Min.	Oct 22,	19	16	Mar	yland	
	and and		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town	r Location	ion							11	Od. Inside City	Limite
	Maryl	to	Maryland Baltimo	re	Catons									"	1 Tes 2	
	r 28a	Director	10e. Street and Number		33331.0		10f. Zip Cod	le	_		-	10g. Citi:	zen of Wh	at Coun		
	23a c	al D	311 Harlem Lane				212	228				US	A			
	Itams ;	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S.	13. Was	Decedent of	of Hisp Juban,	panic Orig	gin? (Spec	cify Yes or No-		14. Race -	America White, 6		
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ➡ Widowed 4 ☐ Divorced	1 Tes 2 ( If Yes, Give Year or Dates	-	_	Yes 21		Specify:		,,		Specify:		ite	
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215	within 7; ene. than "n be wedi	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4c		ive kind	d of work do NOT use ret	ne du	ring most	of workin	g	TOD. IXII	id or busin	1033/1110	ustry	
7	filed within Hygiene. Athar than ant, the We	Соп	12			emal	ker					Own	Home	e		
and	be fill Hall Hall Hall off	Be	17. Father's Name (First, Middle, Last	)				1	8. Mothe	r's Name	(First, Middle, I	Maiden .	Sumame)			
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Ē,	is 1 and 2 of Health itam 27   othar tra	1	20a. Method of Disposition		20b. Place of D	sposition	n (Name of			Da	eytown		21/8 cation - Ci		vn, State	
E 0			1 ⊈Burial 2 □ Cremation 3 □ 1 □ Cremation 3 □ Other (Special		• Woodla		emete	,	1	1/26	/04 W	lood 1	oodlawn, Maryland			
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	nsee		22 Na	me and Add	dress	of Facility	,						_
8	90 E 29		Hotel J.	tolad		/	/36 Ed	imoi	ndsor	a Ave	nue: Ca	aton	uneral Home, Inc. tonsville, MD 21228			28
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus one cause on each	ed the death. Do not line.	enter the	ne mode of d	dying,	such as	cardiac or	respiratory arre	est,			Approximate Interval Betwee	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Sei	ture di	cord	der								Onset and Dea	ith
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	MEN.	er	Sequentially list conditions, if any, leading to immediate	D	s a consequence of)							_		-		-
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С												
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8760,	ficate be executed I physician and is the burial-transit	dlcal		d												
	n certific anding p use as	/Me	IF FEMALE:	23c. If yes, outcom	e of pregnancy											
Вох		clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death		opic pregnar					23	3d. Date o Month		∕ Day Year	ir
0	that the deati ed by the atte detached for	Physiclan/Me	1 ☐ Yes 2 █ No 9 ☐ Unknown	9□ Unknown			ioi (specify)									
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Record	e law r has be ge 2 sh	Completed	14pe 2 12ias	ets melli	tus, Hr	per	tensi	سُن	·		24a. Was an		24b. Wer	e autops	sy findings avai	ilable
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Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				24			Check only one					
of	Phys or this oral di	: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpai	And the second s		DOA 28c. In				d. Describe ho			Specify)		
on	ttending I death. stor: After the funer	atior	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, D	ay Year) Inju		W	∤ork?	s 2 □ N			iv injury	000011100			
Division	or Atten after deatl Diractor: In by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	200. Place of II	njury - At home, farm atc. (Specify)	street, fa	actory, office	e		28	f. Location (Str	eet and	Number o	r Rural I	Route Number,	
	ital or A irs after rai Dira lled in by			1							City or Town,					
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	miles. On the pasis	t of my knowledge, d of examination and/o	ath occu	urred at the gation, in my	time,	date and	place, and	d due to the ca	use(s) a	nd manne	r as stat	ed, ne cause(s)	
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)	- 3 - 0		1/1/2		A.					2/			signed (M	-		
	10	-	30. Name and address of person who	completed cause of	death (Item 23a) (Tv	e, Print)	)	درد	- 6	اد.		1/	27/	7		
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A. Alan Russinger III M. D. 700  31. Data filled (Month Pay Year)  32. Registrate Silvature							cipe	e Rd	Car	Arrec	rille	MD	
	Sta Registra		31. Date filed (Month, Day, Year)	Selection (Months, Day, 1947)											2126	8

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 20, 2004 4c. County of Deeth HILTGUNT MARGRET ZASSENHAUS, M.D. /Medical November 1:30A4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 7028 Bellona Avenue Baltimore
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Baltimore County 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (Stete or Foreign Country) **Funeral** 1 □ M 2 □ F Director 88 214-44-6980 July 10, 1916 Germany Usuel Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore County Baltimore 10e. Street and Number 10g. Citizen of What Country? 7028 Bellona Avenue 21212 or Items 23a USA by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 5 No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. and 1 tem 27 Is marked other than \*natural', or Ite 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Julis H. Zassenhaus Margret 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lowell R. Bowen, Esq. (Attny) One West Pennsylvania Ave., Towson, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Bunal 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 0 permit. Page Department o Important: If any injury or Green Mount Cemetery 11/23/2004 Baltimore, Maryland 2121 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruson Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, arry 1 and 21 212 approximate shock, or heart failure. List only one cause on each line. Martin D. Lawson Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): **Examiner** FRAILTY OF ADVANCED AGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Examine ALZHEIMER'S DISEASE To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) the attending physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? NA Day Year 5 Other (specify) P.O. 1 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ HYPERTENSION cate has been signated by page 2 should by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe certificate 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. filled in by the fo 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after within 24 hours a To the Funerel 6 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Charles 9 Haile 40 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number MD. D17008 PERSONAL PHYKICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES HAILE MD TONSON, MD 7505 OSLER DRIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

NOV 3 0 2004

			For State Registrar		State of N	Maryland / Dep Ce	artment of F ertificate of			iene g. 200	14 37768	3
100	Physicia	N.	1. Decedent's Nan	ne (First, Middle,	Last)				2. Date of Deat Month	h Day	3. Time of Death	
	/Medic		01a	Mae	Allen				11	8	2004 4:00	M
	Examin	ęr			give street and number		4b. City, Town, o	r Location of De	eath	4c. County	of Death	
ě.			Southern 5. Social Security		nd Hospita	1 Age (In yrs. last birthday		Clinton If Under 24 H			e George's	/
	Funeral Director		250-78-8		1 □ M 2 X F	57 Yrs.	Months Days		lin. (Month, Day,		Birthpface (State or Forei Country)	
	JII EC (OI		Usual Residence			31			3/20/194	ŧ/:	South Carolina	а
nylanı	how		10a. State	10b. County		10c. City, Town or L	ocation				10d. Inside City Limi	
e Ma	3a-f s	cto	MD		George's	C1	inton				1 <b>∑</b> Yes 2□N	10
ith th	tems 23a or 28a-f show er mast be notified at	Director	10e. Street and No				10f. Zip Code		10	0g. Citizen of V	Vhat Country?	
aath v	s 238			ynndale	Dr.	et Europie II S		0735	(Casalty Van as Na	USA	A e - American Indian,	
-0036 hours after death with the Maryland	if Health and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23a other treumatic event, the Medical Eyer if retinati	by Funeral		rried 2 <b>X</b> Marri	Armed Force	s? ₹No	If Yes, specify Cuba		(Specify Yes or No- lerto Rican, etc.)		k, White, etc.	
5-00 72 hou	eture icul E		/0	15. Decedent	s Education	16a. Dec	edent's Usual Occup	pation		16b. Kind of Bu	Black usiness/Industry	_
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d 21	/giene	Соп		th			Fore	man		1	Private	
pul eq	tal Hygie d other event, II	Be	17. Father's Name						Name (First, Middle, M	Aaiden Sumam	e)	
aryla should b	i and Mental is marked reumatic ev	ဥ	Jerry		Staples						lade	
Maryland 21215-0036 date 2 should be filed within 72 hours aft	th and 7 is n treun	8 4	19a. Informant's N		n/Husband		Gwynndal		Rural Route Number, Clinton, M			
(a)	Health tem 27 other tr	1.	20a. Method of Dis	sposition		20b. Place of Disp	osition (Name of				City or Town, State	
Baltimore,	Department of I Importent; If ite any injury or ot QDCs.		Burial 2	Cremation 5 Other (Sp	3 Removal from Sta	(9	ematory`or other plac	1			•	
	orten orten injur	1	21. Signature of			an veter	ans Cemete 22. Name and Addre	ery : I	1/16/2004 .B. Jenkin	Cuerrei	nam, MD	_
m §	Depa fmpo any i		1.	D. Ha	ahall	26	474 Lando		Landove		20785	
	5		23a. Part1. Enter	the disease, or o	complications that caus	ed the death. Do not er	nter the mode of dyin	ng, such as card			Approximate Interval Between	
Ph	ysician		Immediate Cause	(Final	only one oddse on odd	Orlata	- eT0	· ke			Onset and Death	
/1	Medical		resulting in death		Due to (or	as a consequence of):	5/100		-		an pros	
Ex	aminer		Sequentially list o	onditions	b	Sev	7 Hy/	estar.	Siev		Elmown	
9	=======================================	Iner	Sequentially list of any, leading to it cause. Enter Und	mmediate lerlying	Due to (or	as a consequence of):						
<b>8760,</b> ate be executed	physician and the burial-transit	Examiner	Cause (Disease of that initiated even resulting in death)	ts	c.	as a consequence of);						
8760, cate be ex	ician				200 10 (01	as a consequence or).						
687 ificate	phys s the	dic			d.							
X cert	attending pt d for use as t	Physician/Medical	IF FEMALE: 23b. Was decede	nt prognant	23c. If yes, outcor	ne of pregnancy				23d Dat	e of delivery	
Box death cert	e atter	clar	in the past 1:	2 months?			□Ectopic pregnancy □ Other <i>(specify)</i> _	<i>'</i>		Mor		
P.O.	ed by the detached	hys	9 Unknow		9 Unknown						W	
	igned be det	by P	Part II. Other sign	ificant condition	ns contributing to death	but not resulting in the	underlying cause giv	en in Part I.	23e. Did tob	acco use contr	ibute to the cause of death?	
ords,	U) T)		Reno	I Fo	uline				1 □ Ye	s 2 No	3 Probably 4 Unknown	rh _
a w	N 50	Completed	Dia	Setis					24a. Was ar	24b. V	Vere autopsy findings availab	le
F 2	ate ha	mo:							perform	red?/ d	leath?	
of Vita Physicien:	is certificate director, pag	Be	25. Was case refe	erred to medical				26. Place of E	Death (Check only one			
of V	this craf dire	2	1 Yes 2	ZN	Hospital:			4 🗀 1401 211 l	g Home 5 Reside			
Ing F	fter	Certification:	27. Manner of Dea	5 🗌 Pending	1	Day Year) 28b. Time Injury	Wor		28d. Describe ho	w injury occurr	ed	
Division or Attending	death. c <b>tor:</b> A / the fu	icat	2 Accident 3 Suicide	investig 6 🗌 Could n	at ha	Injury - At home farm -		Yes 2 □ No	28f Location (Str	eet and Numbe	er or Rural Route Number.	
Div	after death Director: I in by the	ertif	4 Homicide	determi	building,	Injury - At home, farm, s etc. <i>(Specify)</i>	reet, factory, office		City or Town,		or nural noble Number,	
Hospitel	24 hours a Funeral I	705	29a. Certifier	1 Certifying	Physicien: To the be	st of my knowledge, dea	th occurred at the tin	ne, date and pla	ace, and due to the ca	use(s) and mai	nner as stated.	
e H	within 24 hours after o <b>To the Funeral Direc</b> completely filled in by	edica	(Check only one)	2 Medical E	xaminer: On the basis and manner	of examination and/or i	nvestigation, in my o	pinion, death o	ccurred at the time, da	te and place, a	and due to the cause(s)	
To th	within 24  To the Ficomplete	Me	29b. Signature an	d title of certifier			29c. Licens	e number	29	d. Date signed	(Month, Day, Year)	
^			An	Mes v	rdun's	いわ	504	54	N	Vemb	es,8,04	
	(2)		30. Name and add	dress of person v		f death (Item 23a) (Type	. Print)					
			98016	00091	a 3-41		ei-gmD	2090	o Z / Aras	too Yaz	dani, M.D.	
'n	Sta		31. Date filed (Mo			strar's Signature						
4.0	Registr	ar	N	OV 1 6 2	004	w K A						

State of Maryland / Department of Health and Mental Hyginal L 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Angelina Josephine Anderson November 10 2004 /Medical 12:00 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Villa Rosa Nursing Home Prince George's Mitchellville Sept. 16,1921 Wash., D.C. 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours 1 □ M 2 💢 F Director 577-16-9286 83 Yrs Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. and telms 23 so 28a-1 show ant: If them 27 is marked other than "natural", or Items 23a or 28a-1 show r 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Queen Anne's Chester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tem 27 is marked other than "natural", or items 23a or other traumatic event, it is New Call Examiner must be a 403 Widgeon Way 21619 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 X Widowed 4 □ Divorced Specify: White 15. Decedent's Education Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Grasso ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Mann / daughter 403 Widgeon Way Chester, MD. 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State ö 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. `4 Donation 5 Dother (Specify) Ft. Lincoln Cemetery | 11-12-2004 Brentwood, MD. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service License 6512 NW Crain Hwy. Bowie, MD. 6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) 3-4 day. /Medical Due to (or as a consequence of) Examiner Alzheimeis Dementia Tovanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death Yes 2 No 9□ Unknown 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ste00960511 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 200 No 2 No 1□ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) e Hospital or Attending Pl 24 hours after death. e Funeral Director: Atter to Certification: 28b. Time of Injury at Work? 28d. Describe how injury occurred Matural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} 24 hours a Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 037934 30 10/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephanie Trifoglio, M.D. 7500 Greenway Ctr. Dr. Greenbelt, MD. 2. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 1 5 2004 Registrar

os -			1- For Unpend Item Registra Amend Item	23\( \frac{1}{2} \) 23\( \frac{1}{2} \) 32\( \	id/Dep 63 3/20	stment of 1 1838 12-1 Wisaterof	lealth and 5-04 tas Death			37770
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2	Examir	ner	4a. Facility Name (If not institution, giv 3706 Dunlap Stre	eet		Temple			4c. County of D	e Georges
166	Funeral Director		5. Social Security Number 6. S 578-70-9863	MM 2□ E	last birthday) 52 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day)	<b>5–30–1952</b> <del>7</del> 9ar) <del>752</del> ₩a	Birthplace (State or Foreign County) ashington Do
	the Maryland 28a-f show notified at	tor	10a. State 10b. County		y, Town or Lo	cation Hills				10d. Inside City Limits 1
	with the 3a or 28	I Direc	10e. Street and Number 3706 Dunlap St	reet		10f. Zip Code 2074	8	1	0g. Citizen of What	Country?
920	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It amd Mental Hygiene. It is marked other than "natural", or Items 23a or 28a-f show traumatic avent, the Madical Examinat must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 (XYes 2 () No If Yes, Give Year or Dates:			Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		
Maryland 21215-0036	d within 72 ho giene. er than "natur the Medical	Completed	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)	(Give life. I		during most of wor	king	Prime transpo	
yland	should be filed nd Mental Hyg marked othe matic avent,	To Be C	17. Father's Name (First, Middle, Last, Francis William				18. Mother's Nam Evely	ne (First, Middle, M n Nesbi	Maiden Sumame) t Meyers	5
	1 an Heal am 2 thar		19a. Informant's Name/Relationship ( Wanda A. Ashe/  20a. Method of Disposition	spouse	3706	Dunlar	Street	Temple	City or Town, State	MD 20748
Baltimore,	permit. Pages Department of I Important: If its any injury or of		1 Spurial 2 Cremation 3 C 4 Oonation 5 Dotter (Specification 5 Dotter (Specification) 5 Dotter	che	eltenh	. Name and Addre	Cem 11/	22/04	Cheltenh	
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	w requires that been signed b should be deta	by P	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the un	derlying cause giv	en in Part I.		_	to the cause of death?  Probably 4 □Unknown
al Reco	ician: The law re certificate has be ector, page 2 sho	Completed						24a. Was an autopsy perform	prior to	
Division of Vital Records,	or Attending Physiter death. Director: After this n by the funeral dii	Certification; To Be	25. Was case referred to medical examiner?  1  Yes 2  No  27. Manner of Death 1  Natural 5  Pending investigation 3  Suicide 4  Homicide 6  Could not be determined	Found: Day Year)  11—13—()  28e. Place of Injury - At ho building, etc. (Specify	Pound a seco	28c. Injury Work	er: 4 □ Nursing Ho yat k? Yes 2 <b>√2</b> No	Jnknown 28f. Location (Stre. City or Town,	nce 6 Nother (Sp vinjury occurred set and Number or F State) 3706	ecify) at scene  Gural Route Number,  Jun 1 ap Street
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	Found at res  ysician: To the best of my know  iner: On the basis of examinat and manner stated.	wledge, death	occurred at the tin estigation, in my o	ne date and place	sud due to the car	IIS, Mary	riand
	To th withir To th comp	Me	29b. Signature and title of certifier	lah Ali-		29c. Licenso	e number CME		d. Date signed (Mor ovember 1	
H	~2	1.5	30. Name and address of person who of 24/3/4 CLAM	completed cause of death (Item	23a) (Type, F	111 Pe	nn St <b>re</b> et	, Baltim	ore, Mary	land 21201
	Sta Registr	-	31. Date filed (Month, Day, Year) NOV 2 2 2	32. P gistrar's Signat	lure A	house				

			1- State of Maryland / Department of Health Certificate of Dea	46	/giene 004 37771
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Novine Adell	2. Date of De Month	eath 3. Time of Death
1	Examir	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location  Southern Maryland Hospital Center  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 1		4c. County of Death Prince George's
L	Funeral Director		216-80-7392 1 M 2 F 91 Yrs. Months Days Hour Usual Residence of Decedent		o. Birthplace (State or Foreign Country) Mary land
	the Marylar 28a-f ahow cliffed at	ector	10a. State 10b. County 10c. City, Town or Location  Maryland Prince George's Accokeek		10d. Inside City Limits 1 ☐ Yes 2 📉 No
9200	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, itam 27 is marked other than "natural", or Items 23s or 28s-f ahow other traumatic event, the Medical Eventinat must be redified at	d by Funeral Directo	10e. Street and Number  16224 Livingston Road  11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced  10f. Zip Code  20607  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No If Yes, specify Cuban, Mexital Status 1 Yes 2 No Specify Cuban, Mexital Stat		United States  14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	2 should be filed within 72 hours aft and Mental Hygiene, is markad othar than "natural, or aumatic evant, the Medical Evami	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  8  16a. Decedent's Usual Occupation (Give kind of work done during n life. DO NOT use refired)  Homema ker	nost of working	16b. Kind of Business/Industry  Own Home
Maryland ;	should be filed nd Mental Hygir markad othar umatic evant, I	To Be C	17. Father's Name (First, Middle, Last)	other's Name (First, Middle,	
	t and 2 sho Health and Im 27 is m thar traum		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Nur  Margaret Scarborough-daughter  20a. Method of Disposition  20b. Place of Disposition (Name of	Rd., Accokeel	k, MD 20607
Baltimore	Page nent c ant: If ary or	1 1	20a. Method of Disposition  1 M Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signalure of Funeral Service Licensee  M00053  22. Name and Address of Fa	11-13-2004	Waldorf, Maryland
Ba	permit. Departr Imports any inji		Huntt Funera P.O. Box 156  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such		D 20604-0156 rrest, Approximate
	Pnysician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of):	arrest	Interval Between Onset and Death
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x 68760,	ertificate b ling physic e as the bi	Medical	d. Hyper tension		
.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1		23d. Date of delivery Month Day Year
rds, P.	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Particular Conditions.		obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
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of Vita	Physician: Th this certificate al director, paç	To Be	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4		dence 6 □Other (Specify)
Division	al or Attending Ph s after death. I Diractor: After th d in by the funeral	Certification:	27. Manner of Death  1	□No	Now injury occurred  Street and Number or Rural Route Number,
Div	pital or ours afte aral Dir		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date	City or Tow	vn, State)
	To the Hos within 24 ho To the Fun completely f	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, d and manner stated.  29b. Signature and title of certifier  29c. License numbe	death occurred at the time, o	date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
(			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	63	11-08-2004
J.	B 6 Sta	te	9400 Livingston Road, \$350 Fort Washington  31. Date filed (Month, Day, Year)  32. Rankstrar's Signature	on, MD 207	44
•	Registr		NOV 1 2 2004 Mercue & Specific		

State of Maryland / Department of Health and Mental Hygiene 001.

				,	Cert	ificate	of Death	,	Reg. No.	UL	31112
		1. Decedent's Name (First, Middle, L	ast)	<del></del>				2. Date of De Month		Vaar	3. Time of Death
	Physician /Medical	Cynthia Frances	Bates							Year 2004	8:00 am
1	Examiner	4a Facility Name (If not institution, g	ive street and number)				4b. City, Town, o	Location of Deat			0100 0111
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	arylar ahow	10a. State 10b. County		10c. City, Tow	n or Loca	ation				100	d. Inside City Limits 1 ☐ Yes 2 ☐ No
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	or 28a-f a	10e. Street and Number				10f. Zip Co	de		10g. Citizen of	What Country	у?
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	r kema 234 olber muni Furneral	11. Marital Status	12. Was Decedent Armed Forces?		13. W	as Decedent Yes, specify	of Hispanic Origin? ( Cuban, Mexican, Pue	Specify Yes or No rto Rican, etc.)		ce - America/ ck, White, at	
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an	d be find H and of the control	Lawrence C. Sc					01 1111	a Mac Da			
2	should be and Mentel marked of umatic ev	19a. Informant's Name/Relationship	TITLE SOUN	198	. Mailing	Address (St	reet and Number or F	a Mae Tu Bural Route Numb		Stete. Zip C	Code)
Ma	d 2 s ther Tie	William R. Bate								247355	
ē,	Heal Heal	20a. Method of Disposition	s/ Husballu	20h Place 0	f Disposi	tion (Name o	ourt, Silv	Date	20c. Location		m, Stata
ē	ages in the state of the state	1 □ Burial 2 □ Cremation 3		Ar Li		n Nat	ional	Nov. 22 2004			
Baltimore, Maryland 21215-0020	permit. Pages 1 end 2 should be filed within Department of Health end Mentel Hygiene. Important: if item 27 is marked other than eny injury or other treumatic event, the Mannes.  To Be Compl	4 Donation 5 Other (Spec 21. Signature of Funeral Service Lice				tery	ddress of Facility	1	Arlingt	on, Vi	irginia
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1	Physician										Onsat and Death
1	/Medical	Immediate Cause (Final disease or condition	Sepsis								24 Hours
	Examiner	resulting in death)	6	Due to (or as a	consequ	ence of):				1	11 110410
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8	oe ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Alzheim	er's De	ment	.ia				. 2	2 Years
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o O	nat the death ce d by the attend detached for us.	Part II. Other significant conditions	contributing to death be	ut not resulting i	n the unc	lerlying cause	e given in Part t.	23b. Did	tobacco use co	ntribute to t	the cause of death?
P. O.	v requires that the death ce been signed by the attendi should be detached for use leted by Physician/I							10	Yes 2 No	3 Proba	ably 4 Unknown
Vital Records,	signer d be d							24a Was	an autopsy	24b. Wer	e autopsy findings
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₹	Physician: rthis certific rel director, r: To Be	25. Was case referred to medical examiner?	Hospital:				Other	eath (Check only			
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ב	fing F After funer	1 ☑ Netural 5 ☐ Pending	(Month, De	y Year)	njury		Injury at Work? 1 ∐ Yes 2 ∐ No	200. 0000100	now injury occur	100	
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Division	tal or Attanding P rs after deeth. al Director: After t led in by the funers Certification:	4 ☐ Homicide determine	building, etc	c. (Specify)	, Sue	ot, lackery, on		City or To	wn, State)		louis rumsur,
	To the Hospital or Attanding Physician: The is within 24 hours after deeth.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page  Medical Certification: To Be Com	(Check only 2   Medical Ex	Physician: To the best of aminer: On the basis of	examination an							
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	7	A XIVITY ON			-		010105796	1	1000	110	
		30. Name and address of person who William Jackso					Med C+~\	6900	Georgia	Ave.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Ctat	31. Date filed (Month, Day, Year)		walter ar's Signature	<u>need</u>	ATIMY	Med. Ctr)	Wash	ington,	DC 20	307
	State Registrar	NOV 1 2 20		me L	9	Roak	61				

			For State Registrar	State of N	Maryland / Dep Ce	ertificate of			giene 0 0	4 37773
	Physici		1. Decedent's Name (First, Middle,					2. Date of Dea Month	ath Day	3. Time of Death
	/Medic Examin		Francis Jo 4a. Facility Name (If not institution,			4b. City, Town, or	r Location of	November Death	4c. County of	
			Bonds Forest As			Finksb				rroll
	Funeral Director		217-18-0286	1. Sex 7. A	Age (In yrs. last birthda) Yrs.	Months Days	If Under 2 Hours	Min. 8. Date of Birt (Month, Da)  June 1	y, Year) 1915	B. Birthplaca (State or Foreign Country) Canada
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation.				10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show rmust be notified at	tor	Maryland Carrol	7	Fin	ksburg				1 ☐ Yes 2 <del>∏</del> No
	ith the	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	ath w	rail	2261 Old Westmi	-		21048			USA	
	Items Instru	nue	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie	12. Was Deceder	nt Ever in U.S. 13	Was Decedent of H If Yes, specify Cuba	ispanic Origi In, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Black,	American Indian, White, etc.
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au	ld be ental ked o	To Be	William Bailey	Ť				nie Hitchin		
Maryland	shou and M s mar	-	19a. Informant's Name/Relationship		19b. Mai	ing Address (Street a		or Rural Route Numbe		ate, Zip Code)
	and 2 ealth a n 27 ls		Jack F. Bailey	Son	5300	Sweet Air	Rd.	Baldwin, N	10 <b>21</b> 013	8
ore	ges 1 t of He If iter or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3	☐Removal from Stat	9	amatory or other plac	-	Date	20c. Location - Ci	ty or Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.		`4 Donation 5 Other (Spe	cify)	Sandy Mou	int Cemete				g, Maryland
Ba	Depa Impo any ii		21. Signature of Funeral Service	ensee	1	22. Name and Addres		PLICUS FUI	eral Hom	e & Chapel, PA D 21157
			23a. Parti. Enter the disease, or co shock, or heart failure. List or	implications that cause by one cause on each	ed the death. Do not en line.	iter the mode of dying	g, such as c	ardiac or respiratory are	rest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a	nobrou	aseu	lan	acci	dent	Onset and Death
	Examiner		Tooding III dodning	Due to (or a	is a consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	is a cons-quence of):					
	cuted nd ransit	Examiner	that initiated events	c						
9	cate be executed bhysician and the burial-transit	Ex	resulting in death) Last	Due to (or a	is a consequence of):					
8760,	physic physic s the b	Physician/Medical		d						
Вох 6	that the death certificated by the attending posterior detached for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23d. Date of	f delivery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant		⊒Ectopic pregnancy □ Other (s <i>pecify)</i>			Month	,
<u>о</u> .	at the	Phys	9 Unknown	9□ Unknown						
Records,	The law requires that the death certificate be executed at has been signed by the attending physician and rage 2 should be detached for use as the burfal-transit	þ	Part II. Other significant conditions  Attended c	lest C	but not resulting in the	underlying cause give	en in Part I	239. Did to	0.	ite to the cause of death?  Probably 4 Unknown
eco	law re as bee 2 sho	Completed						24a. Was a		re autopsy findings available r to completion of cause of
<u>~</u>		Con						perfor	med? dea	th? Yes 2 No
Vital	icien certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		Othe		of Death Check onl or	-	Assisted
of	> 00	. To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of In	jury 28b. Time of	of 28c, Injury	" 4 ☐ Nurs	sing Home 5 Reside	ence 6 X ther own injury occurred	(Specify) Living
on	ath. r: Afte e fune	atior	1 Natural 5 Pending 2 Accident investigat	(Month, D	Day Year) Injury	of 28c. Injury Work	(? ∕es 2∐No		, , ,	
Division of	I or Attending Fatter death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could no determine	28e. Place of It	njury - At home, farm, si	reet, factory, office		28f. Location (S. City or Town		or Rural Route Number,
	urs aft rral Di	Cer						N.		
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier  (Check only one)  Certifying  2 Medical Ex	Physician: To the bes aminer: On the basis and manner s	t of my knowledge, dea of examination and/or in stated.	th occurred at the time exestigation, in my op	e, date and pinion, death	place, and due to the coccurred at the time, d	ause(s) and manno ate and place, and	er as stated. due to the cause(s)
	within To th compl	Me	29b. Signature and title of certifier	*		29c. License			9d. Date signed (A	fonth, Day, Year)
١	NJ		Hause	fe-		Das	112		11/08/9	2004
	5		30. Name and address of person		O	Print)	1- N-	- Suite	101 4.	110 MD21117
	Sta	te.	31. Date filed (Month, Day, Year)	awa CA 32 Regis	Mar's Signature	OSSYGOC	V3 V1	own	ngs M	. 00
	Registr			9 2004	Coerce &	Locale			d	

DHMH 17 Rev 1/2001

Maryland 21215-0036

P.0. Division of Vital

Amended Item 25 per M.E. 11/10/2004 Carroll County, will Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37774 Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Patricia J. Buhl 10 3:00 P M 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 58 Director 215-42-9194 Yrs Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or Items 23a or 28a-f show Injury or other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Carroll Finksburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21048 USA 1613 Davinda Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 Yes 2₺ No White δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Supervisor C&P Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If tiem 27 is marked oth any lipiry or other treumatic event 2008. William F. Yates Irene Sanders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1613 Davinda Dr. Finksburg, MD 21048 James Buhl, Jr. (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial Park 11/3/2004 Sykesville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Burrier-Queen FuneralHome and Crematory, P.A. 21. Signature of Funera 1212 West Old Liberty Rd. Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute eshiratez Priysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit With Transper Myelity IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 DAY 1 ☐ Yes 2 ☐ No 1 🗌 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Thipatient 2 ER/Outpatient Certification: To XXYes -2 3 DOA 28a. Date of Injury (Month, Day Year, 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 TSuicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 00051924 29d. Date signed (Month, Day, Mea) TUN who completed cause of death (Item 23a) (Type, Print)

B Keener, S49 Mal 6 Keener Malenhydur West more, Kaman 32. Registrar's Signature 31. Date filed (Month, Day, Year) State com it species Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Garnett Lloyd Baldwin P M November 2004 9:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 1258 Turkey Point Road Edgewater Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 ☐ M 2 🂢 F Yrs. Director 217-06-2233 81 9-29-1923 Virginia Usual Residence of Decedent the Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or ftems 23a or 28e-f shov other treumatic event, the Madical Extripitatings to notified at Maryland Anne Arundel Directo Edgewater 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ould be filed within 72 hours after death with Mental Hygiene. 1258 Turkey Point Rd. 21037 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be r is marked Oscar Athey Lloyd Ella Blanche Lloyd Pages 1 and 2 should nent of Health and Men 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: if item 27 is any injury or other treu QDCs. 7570 Ryders Rest Ln., St. Michaels, MD 21663 Carol B. McCollough/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery | 11-10-04 4 □ Donation 5 □ Other (Specify) Crownsville, MD 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Roberto Illela 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congective Huler Month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed as the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Ą Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ diabetu Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan this certificate has autopsy 2XINo 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 XResidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Director: / 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funerel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie cal (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed/(Monthy Day, Year) 04 D38158 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2003 ITEMICAL Park Way, SVI (20), Lisa A. DiMarzio, strar's Signature 31. Date filed (Month, Day, Year) 32. Registrar

Amend item/18, perinf, G838, 12/3/04 TI

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Roger McArthur Cabiness 10 2004 2:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1**X** M 2□ F Director West Virginia 063-34-9498 12/25/1942 Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State traumatic evant, the Medical Examiner must be notified at 1 Yes 2 No Director Prince George's Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5311 Lakevale Terrace 20720 Completed by Funeral USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. iiled within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 € No Specify: 3 Widowed 4 Divorced "natural" **Black** Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry d 2 should be filed within 7 hand Mental Hygiene.
7 is markad othar than "I Elementary/Secondary (0-12) College (1-4or 5+) DC Public School Teacher Gov't 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Cleveland Cabiness Grover Rosetta Rosella Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If itam 27 is a Helen Cabiness/ Wife 5311 Lakevale Terr. Bowie, MD 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ō permit. Page Department of Important: If any injury or once. Harmony Memorial Park 11/16/2004 Landover, MD Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter It as eas or come! It is that caused the shock, or heart failure. List only one cause on each line Irons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Hepatic Encephalopathy Days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Liver Metastic Disease Months Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Stage four Adenocarcinoma of Lung Years Due to (or as a consequence of): attending physician Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, ρĄ Tobacco Abuse Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 22 No 24a. Was an Essential Hypertension autopsy nerforme 1 ☐ Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 of SIL 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Diractor; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MUD 3106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. George Bone, MD 1100 Mercantile Lane Suite#135 Largo, MD 20774 Dr. George Bone, MD 31. Date filed (Month, Day, Year) . Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

NOV 1 6 2004

			1 - State Registrar	-	artment of Health and N tificate of Death	Reg. I	2004 3///					
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	~		2. Date of Death	Oay 3004 1135 PM					
	Examin		4a. Facility Name (If not institution, give street and n  MERCY Hospital		4b. City, Town, or Location of Death BACTIMORE		4c. County of Death					
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2√√ F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Feb. 23, 19	946 Shirthplace (State or Foreign Country) Ohio					
	land ow		Usuel Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits					
	Mary a-f sh	tor	Md. Prince George	es Bowie	e		1 X Yes 2 No					
	or 28	Oirec	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Country?					
	s 23s	rall	1518 Perrell Lane		20716		SA					
920	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I then the marked other than "natural", or Itams 23a or 28a-f show item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, Ita Madical Evanting right by mylliked at	by Funeral Director	Armed F	2 🔀 No live	Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
Maryland 21215-0036	ithin 72 ho ne. nen "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)  College	(Give (1-4or 5+)	lent's Usual Occupation kind of work done during most of work DO NOT use retired)	ring	Kind of Business/Industry					
22	filed within Hygiene. other than "		17. Father's Name (First, Middle, Last)	2 Self	employed  18. Mother's Nam	e (First, Middle, Maide	ntiques					
au	lid be lental ked o ic eve	To Be		M. Coggeshall		orinne Bea	· ·					
ary	2 should be and Mental is marked o aumatic eve		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number or Rur	al Route Number, City	y or Town, State, Zip Code)					
	1 and 2 Health tem 27 other tra		Ralph Conlin - husband		Perrell Lane, Bow							
or D	00		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from	I State		4-04	Location - City or Town, State					
Baltimore,	permit. Page Department Important: I any Injury o		Metropolitan Crematory  Alexandria, V  21. Signature of Funeral Sprice Lighter  22. Name and Address of Facility  Beall Funeral Home  6512 N.W. Crain Hwy., Bowie, Md. 20715									
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the deeth. Do not enter			Approximate Interval Between					
	Priysician		Immediate Cause (Final disease or condition		IN FARCTI	Sec.	Onset and Death					
	/Medical Examiner			(or as a consequence of):	2225 - 115	4.0	0.000					
	1	ē	Sequentially list conditions, if any, leading to immediate	(or as a consequence or):	IC CARDIOVAS	COLAR	DISEASE					
	cuted od ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
8760,	ate be executed hysician and the burial-transit	il Ex		o (or as a consequence of):								
687	ficate t physics the t	edicai	d									
P.O. Box (	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	in the nast 12 months?	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year					
	quires that in signed b uld be deta	by	Part II. Other significent conditions contributing to H(GH BLODD	death but not resulting in the ur りんを550 ルモ	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?  2 No 3 Probably 4 7 Inknown					
of Vital Records,		Completed				24a. Was an autopsy performed?						
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:		Othor	h (Check only one)						
To	di S	1: To	1 162 5 100	Inpatient 2 ER/Outpatien of Injury onth, Day Year)  28b. Time of Injury		ome 5 Residence 28d. Describe how in						
ion	nding ath. r: Afte e fune	atior	1 Natural 5 Pending (Mo 2 Accident investigation	nth, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No							
Division	tai or Atte s after de al Directo ed in by th	Certification:	3 Suicide 6 Could not be determined 28e. Plate buil	ee of Injury - At home, farm, strading, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ste)					
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	(Check only 2 Medical Examiner: On the one) and ma	ne best of my knowledge, death basis of examination and/or inv nner stated.	occurred at the time, date and place, vestigation, in my opinion, death occur	red at the time, date a	nd place, and due to the cause(s)					
	To With	Σ	29b. Signature and title of certifier	MS	29c. License number 0 47138	29d. C	Date signed (Month, Dey, Year)					
R_	(6)		30. Name and address of person who completed ca	n 301 St	Print) PHUL PLA	ACE, BA	CT MUS					
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 1 5 2004	Registrar's Signature	W	,	,					

Amend item Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State RegistraryMENC#31, See#32, 11/12/04, EMW, McCo Certificate of Death Reg. No. Decedent's Name (First, Middle, Last)
 DOLORES 2. Date of Death 3. Time of Death **Physician** 2004 DELORES NUTTER 10:12P M Nov. CARTER /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death MONTGOMERY Silver Spring 3124 Gracefièld Rd #403 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🙀 F 76 Director 169-22-1317 Mar. 27,1928 Pennsylvania Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD Montgomery Silver Spring 1 ☐ Yes 2 ☑ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 3124 Gracefield Rd., #403 238 20904 U.S.A. Funeral or Items 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, e filed within 72 hours after all Hygiene "other than "naturel", or Iter 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore Pulbic Elementary/Secondary (0-12) College (1-4or 5+) 5+ Counselor Schools injury or other treumetic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury op other treumetic event any injury op. 18. Mother's Name (First, Middle, Maiden Sumame) Matthew H. Nutter 2 Sadie E. Lisby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 James T. Carter (Husband) 3124 Gracefield Rd., #403, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Parklawn Mem. Park 11/15/04 ' 4 ☐Donation 5 ☐ Other (Specify) Rockville, MD 21. Signature of Funeral Service Lichisee 22. Name and Address of Facility Snow len Funeral Home, F.A. 246 N Washington St Rockville, MD20850 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stroke Days /Medical Due to (or as a consequence of): Examiner Hypertension
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Years Examine The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐ Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No the 9□ Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 WUnknown Dementia 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has I page 2 s autopsy performed? certificate 1 ☐ Yes **¾**□ No Hospitel or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After X-Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Accident hours after death uneral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ determined 4 - Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiei Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

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Roy Fried,
31. Date filed (Month, Day, Year)

non

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

12/

32. Registrar's Signature

DHMH 17 Rev 1/2001

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D34590

3110 Gracefield Rd., Silver Spring, MD 20904

- 410V 1 2 200m

11-8-04

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** NOV 8 2004 10:30 PM Erma Mae Cave
4a Facility Name (If not institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LAPLATA CHARLES 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Months Davs Hours 72 1932 Maryland Director 220-26-2530 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10200 La Plata Rd. 20646 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. Aimed Forces? 1 □ Yes 2 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: þ 3 ☐ Widowed 4X Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home Department of Health and Mentel Hy Important: If Item 27 is marked other eny injury or other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Elmer Asmussen Mary Ellen Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print, Bonnie Kwiec/daughter 6414 Ocelot Dr., Waldorf, MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Localion - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. 13, Charles Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, MD 22. Name and Address of Facility Brinsfield-Echols Funeral Home, 21. Signature of Funeral Service Licenses P.A., 30195 Three Notch Rd., Charlotte Hall 20622 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Sequentially list conditions, if eny, leading to immediale ceuse. Enter Underlying Cause (Disease or injury Division of Vital Records. P.O. Box 68760. thal initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 robably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 20 Other: Medicai Certification: To 1 Tes 2 ☐ ER/Outpatient 3 ☐ DOA npatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28 Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) The Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Dale signed (Mpnth, Day, Year) D-0060181 30. Name and address of person who completed cause of death (Kem 23a) (Type, Print) STACIE GUMP OLD LINE CENTER STE 202&210 WALDORF, MD 20602 MD 12070 31. Dale filed (Month, Day, Year) State **NOV 12** 2004 Registrar

Amended Item #18 per F.D. 11/12/2004 Carro11 County, wj1
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ANNABELLE MARCEIL CROWL 11, NOV. 2004 10:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Manchester Long View Nursing Home If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1 □ M 2 🔀 F 94 Director 212-01-8659 3/4/1910 MARYLAND Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits r then "neturei", or items 23e or 28e-f shov the Medical Examiner must be notified at 11 Yes 2 □ No **Funeral Director** CARROLL WESTMINSTER MD. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 260 E. Main St. USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: WHITE þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOME MAKER 8 17. Father's Name (First, Middle, Last) <sup>18</sup>AMEET A<sup>am</sup>E*GUE SIE*GI<sup>18</sup>STETNBERG Be 1 and 2 should be Health and Mental EDWARD FRANCIS CRAWMER AMELIA LOUISE STEIBERC ပ 9 nackonale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 677 GOLDEN DR., WESTMINSTER, MD. 21157 : If item 27 or other tr BENJAMIN F. CROWL, JR.-SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 Surial 2 Cremation\_3 Removal from State WESTMINSTER CEMETERY 11/13/04 WESTMINSTER, MD. **Jepartment** 4 ☐ Donation 5 ☐ Other (Specify) of Meral Service Licensee 22. Name and Address of FacilityFLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD.21157 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine The law requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 3 P.O. Box 68760. Physician/Medical Due to (or as a consequence of): resulting in death) Last Part II. Other eignificant conditions contributing to death but not resulting In the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown signed by δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No

Division of Vital Records, or Attending Physician:

page death. Director: / To the Hospitai or Atte within 24 hours efter de To the Funerei Directo completely filled in by the

Be

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Certification:

Medical

State Registrar

WIL 15

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D 25443

1 🗌 Yes

2 🗆 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

W. MIDDLETON, M.D. 688 POOLE RD., WESTMINSTER, MD. 21157

31. Date filed (Month, Day, Year)

25. Was case referred to medical

1 ☐ Yes 2 No 27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

32. Registrar's Signature

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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	le le		Registrar  1. Decedent's Name (First, Middle, Last	1			uncate of	Dea	u i	0.0	Reg. N	4-06	J 14	
	Physici	an				,				2. Date of D Month	D	ay	Year	3. Time of Death
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	Funeral Director		5. Social Security Number 6. Se 218-18-3226	x 7. Age	81	last birthday) Yrs.	If Under 1 Year Months Days		der 24 Hrs. rs Min.	8. Date of Bi (Month, D June 2	25,1	923	9. Birth Cou M:	place (State or Foreign intry) aryland
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Maryland	~ ~ ~		Wendy Legerski	pa, riinij			ng Address (Street							-
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Ö	m O		1 ⊠Burial 2 ☐ Cremation 3 ☐ F	Removal from State	1		sition (Name of natory or other pla					Location - C		
	t. Partmer		`4 □ Donation 5 □ Other (Specify)		Wes		ngham Cemet	77.0		.6/04	Col	ora,	Mar	yland
Baltimore,	permit. Page Department of Important; if any injury or 2008.		21. Signature of Funeral Service Licens	HOEDEN.	SC	Le	Name and Address A. Paterryville	ters	son &	Son Fur	nera	1 Hom 0766	e, I	P.A.
	* *		23a. Part1. Enter the disease, or complishock, or heart failure. List only of		-							0,00		Approximate
	Physician		Immediate Cause (Final	DEMEN									1	Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	Due to (or as a		uence of):								
	Examiner													
i d	- 10°	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cheese or a jury that initiated events	Due to (or as a	conseq	uence of):	-						-	
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<u>,</u>	icate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to (or as a	conseq	uence of):								
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Q	ificat g ph) as th													
ROX	feath certificate I attending physi I for use as the b	2	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of								23d. Date	of deliv	arv
	d for	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at t			Ectopic pregnanci Other (specify)	у				Mont		Day Year
j.	t the	hys	9 Unknown	9□ Unknown										
7.	law requires that the death certifica as been signed by the attending ph . 2 should be detached for use as th	by Physiclan/Med	Part II. Other significant conditions con			ulting in the ur	nderlying cause giv	en in Pa	ırt I.	23e. Did	tobacco	use contrit	oute to t	he cause of death?
cords,	n sig	D D	CHRONIC RENAL	INSTPICE	Acy					1 🗆	Yes 2	! □ No 3	B 🗆 Prot	ably 4 Unknown
္ပ	w require been signature	Completed	DATINFOORH LA F	15.0						24a. Was	20	24h W	ore aut	ppsy findings available
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VITAI	ician: Th certificate rector, pag		05 11/00							1 ☐ Yes	S N		Yes	28€ No
5	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			. 30 DOA Ott			(Check only				
Ö	Phy r this ral d	7	1 ☐ Yes 2 No  27. Manner of Death	1 ∐ Inpatien 28a. Date of Injury		ER/Outpatien 28b. Time of	1 3LJ DOA	⊕⁄⊆		ne 5 Resi 28d. Describe				ý)
	ding h. After fune	lon	1 XNatural 5 ☐ Pending	(Month, Day	Year)	Injury	28c. Injur Wor	rk? Yes 2		zou. Describe	riow inju	ry occurred	,	
DIVISION	Attending or death. actor: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	29a Blace of Injur	ar . At he	ma farm sta		103 4	-	20f Lanation (	'C44 -		0	
≥	or A after Dirac in by	rtif	4 ☐ Homicide determined	28e. Place of Injur building, etc.	(Specify	y)	et, factory, office		'	City or To			or Hura	al Route Number,
_	pital ours a eral		29a. Certifier	Notes To the boar	anne I -	udada								
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Mec	29b. Signature and title of certifier	and manner state	eu.		29c. Licens			1		ate signed (		
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

					(	Certificate of	Death		Reg. No. U U	4 3/182
	Physicia	an	1. Decedent's Name (First, Middle, La	st) MELVIN O.	CARLS	SON - SR		2. Date of De Month	eath Day	3. Time of Death Year
1	/Medic		4a Facility Name (If not institution, giv		CUITE		4b. City, Town, or L	NOV . ocation of Deat		
		*	CARROLL LUTHER	AN VILLAGE	;		WESTMIN		CAR	ROLL
9	° Funeral Director		5. Social Security Number  218-10-8520  Usual Residence of Decedent	ex 7. Age (In	yrs. last birtl	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 6 / 1 7	iy, Year)	Birthplace (State or Foreign Country)  MARYLAND
	ylend how	Ì	10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits
	Se-f si	ctor	MD. CARRO	LL	WES	STMINSTER				1 ☐ Yes 2√ No
	th with th	al Director	10e. Street and Number 116 HAHN RD.			10f. Zip Code 2115	57		10g. Citizen of V USA	
21215-0020	urs e	by Funeral	11. Marital Status  1 ☐ Never Married    2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	in U,S.	13. Was Decedent of H If Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		e - American Indian, k, White, etc. :: WHITE
5	72 h	etec	15. Decedent's Ed (Specify only highest gra	lucetion de completed)	16e. l	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of work	ing	16b. Kind of Bu	siness/Industry
121	within than than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		LOGISTICS	a)		ENGINE:	ERING
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	end 2 ealth e ear trai		ALEATHA CARLSO			HAHN RD.	, WESTM			
altimore,	Pagas 1 mant of H ant: If iten ury or oth		20a. Method of Disposition 1 ∰Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery		ETERY 1		4 WEST	City or Town, State MINSTER, Md.
Balt	permit. Depertiments any inj		21. Signature of Funeral Service Licer	see		22. Name and Addre				L HOME , MD. 21157
4		T	23a. Part 1. Enter the disease, or com shock, or hear failure. List only	olications that caused the one cause on each line.	death. Do no	ot enter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final				1 11		1	Onset and Death
	Examiner		disease or condition resulting in death)	a Acute	INT.	recevel	War 14	emm	orhay	Cody
	n =	ner		, Asei		onsequence or):				
oʻ	eath certificata be executed attanding physician and for use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying	0.		onsequence of):				
68760,	tificata be ng physici as the bu	Medical	Cause (Disease or injury that initiated events resulting in death) Last	c. Due	to (or as a co	onsequence of):				
Вох	death cer	an/M		d						
	Q 0 Q	ysic	Part II. Other significant conditions of	ontributing to death but no	t resulting in	the underlying cause giv	en in Part I.		7.1	tribute to the cause of death?
J.	es that the death cigned by the attand be detached for us	by Physician	Advanced D	emento				1 🗆	Yes 2 No	3 Probably 4 Unknown
Hecords,	w requires that the s been signed by th 2 should be detache	Completed b						24a. Was	an autopsy rmed?	24b. Were autopsy findings available prior to completion of cause of death?
	The law ate has b	E						10	Yes 20 No	1 ☐ Yes 2 ☐ No
	ician: The certificate rector, peg	8	25. Was case referred to medical examiner?	No. 2.1	***************************************		26. Place of Deat	h (Check only o	one)	
6	A Sign	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital:	2 ER/Outp		4AL Nursing Ho		dence 6 Othe	
		5	Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Ti	jury Wor	yai k? Yes 2⊡No	260. Describe	how injury occurre	9Q
_	i or Attending after death. Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		At home, farr pecify)	m, street, factory, office	,	28f. Location ( City or To	Street and Numbe wn, State)	er or Rural Route Number,
		edical C		vsician: To the best of my iner: On the basis of exa- and manner stated						
	Withii To th		29b. Signature and title of certifier			29c. Licens			_	(Month, Day, Year)
	WIL			Xfx	2/	13	7949		Nou.	10-en 2004
	W-6		30. Name and address of person Revuelly Br	xelaselu	Sylv	Print) There	ust her	ne, a	estima	10th 2004
	Stat Registra	е	31. Date filed (Month, Day, Year)  NOV 1 0	32. Registrar's S	Signature )	South.				

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 4 37783 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Yee **Physician** 11-59 A M Thelma Rebecca Cumberland November 08 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M % F 88 Yrs. Director 213-05-3846 Feb 25 1916 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Carroll Westminster Director 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? or Items 23a 220 Shipley Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3₩idowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within the and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Presser L. Grier and Brothers 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Byers Dallie Keefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an parmit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or othar trai QDCs. 101 Sullivan Road Westminster, MD Robert Cumberland, Jr/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 11/11/2004 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State

**Physician** /Medical Examiner ^ 4 ☐ Donation 5 ☐ Other (Specify)

Chilu

21. Signature of uneral Se

Immediate Cause (Final

29b. Signature and title of certifier

1.00 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

Tosale

M.D

32. Registrar's Signature

disease or condition resulting in death)

The law requires that the death certificate be executed burial-tran

Box 68760,

P.0.

Division of Vital Records,

or Attending Physician:

After

Director:

death.

Examiner Physician/Medical the s been signed b 2 Completed page 2 s director. Be Certification: To the filled in by

To the Hospital or Al within 24 hours after or To the Funeral Direc W.S 4

Due to (or as a consequence of): Respueton Sequentially list conditions, if any, basing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P 0 Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 Tes 2 NO 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 ⊟Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

29c. License number

39502

Main St.

Meadow Branch Cemetery

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Hims

Hick

Prints Fineral Home and Chapel, P.A.

412 Washington Road Westminster, MD

Westminster, MD

29d. Date signed (Month, Day, Year)

21157

Approximate Interval Between Onset and Death

DHMH 17 Rev 1/200

State Registrar 447,

NOVEMBER 6, 2004 10:35 p.m.

				artment of Health and Me rtificate of Death	ental Hygie Reg.	2004 37784
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last)     Howard William Carrick, Jr.      4a. Facility Name (If not institution, give street and number)			3. Time of Death 6, 2004 10:35 19 4c. County of Death
	Funeral Director		Stella Maris Hospice  5. Social Security Number  6. Sex 1 M 2 F 61 Yrs.  Usual Residence of Decedent	Timonium  If Under 1 Year   If Under 24 Hrs.   8  Months   Days   Hours   Min.   I	B. Date of Birth (Month, Day, Ye Dec. 24,	Baltimore  9. Birthplace (State or Foreign Country) MD
	he Maryland 28a-1 show otified at	ector	10a. State 10b. County 10c. City, Town or Lo MD Queen Annes S	tevensville		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
36	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Macical Examinar must be notified at	by Funeral Director	308 Talbot Road  11. Marital Status  1 Never Married 2 Married   12. Was Decedent Ever in U.S. Armed Forces?   1 Yes 2 Mo   1 Yes, Give   1 Ye	10f. Zip Code   21666    Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ri		USA  14. Race - American Indian, Black, White, etc.  Specify: White
Maryland 21215-0036	ad within 72 hour glene. er than "natural" , the Medical Ex	Completed b	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired) mputer Analyst	7 16b	. Kind of Business/Industry  NSA
yland	od fall be	To Be (	17. Father's Name (First, Middle, Last) Howard William Carrick, Sr.	18. Mother's Name (	rzucco	
re, Mai	1 and Health Bm 27 ther tr		Susan Wagner/Sister 13	ng Address (Street and Number or Rural) Seminary Drive, Luturesition (Name of Date Date   Dat	herville	
Baltimore,	t. Partmer		4 Donation 3 Donat (openity)	natory of other place) SS Cemetery Nov. 200	9, B	Brooklyn, MD  a Park Funeral Home
m T	Departing Department of the policy of the po	-	23a. Part. Enfer the sease, or complications that cause the death. Do not ent super, or hap realing. List only one cause on each are.	95 GOV. RICCITE HWY	, Severn	a Park, MD 21146  Approximate interval Between
	Physician pe executed in India physician and india physician and see as the privat-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  LIVER CANCER  Due to (or as a consequence of):  b.  Due to (or as a consequence of):  c.  Due to (or as a consequence of):			Onset and Death
O. Box 6	death e atter id for u	Physician/Med		Ectopic pregnancy  Other (specify)		23d. Date of delivery Month Day Year
ords, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 XUnknown
Vital Records,	The ate h page	e Completed	OF Was seen referred to medical		24a. Was an autopsy performed? 1 ☐ Yes 2 🛣 i	
ö	iing Phys  After this uneral di	To B	25. Was case referred to medical examiner?  1  Yes 2 No  1  Inpatient 2 ER/Outpatien  27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation			6
Division	oital or Attendurs after deathurs after deathurs Director: ,	Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)		City or Town, Sta	
	To the Hospital of within 24 hours at To the Funeral D completely filled it	ledical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death (Check only one)  Certifying Physician: To the best of my knowledge, death (Check only one)  Medical Examiner: On the basis of examination and/or invalid	estigation, in my opinion, death occurred	at the time, date a	and place, and due to the cause(s)
	To With Con	W	29b. Signature and fittle of certifier	D43725	29d. [	Date signed (Month, Day, Year)
	e e e		30. Name and address of person who completed cause of death (Item 23a) (Type, DR. TARIO MAHMOOD 2300 DULANEY VAL	Print)  LEY RD. TIMONIUM,	MD 21093	,
	Sta Registr		31. Date filed (Month, Day, Year)  32. Refistrar's Signature	book		

		1 - For State Registrar		of Maryla	•		of Hea		d Mental Hy	Reg. N2	0 4	377	
Physic /Medi Exami	cal	Decedent's Name (First, Middle, Elsie Virginia     Elsie Virginia     Fecility Name (If not institution,	a Clark	mber)		4b. City,	Town, or Loc	ation of D	2. Date of D Month Novembe	er 6	Year 2004 ounty of Death	3. Time of 2:36	
Funeral	lei	829 Janice Driv 5. Social Security Number	_	7. Age (In yrs	:. last birthday)	Ann If Under		Jnder 24 l	Ain. (Month, D	irth lay, Year)	ne Arur	place (State o	or Foreign
Director	or	212-58-9167  Usual Residence of Decedent  10a. State 10b. County			Yrs.				June 1	2, 190		y 1 an d  10d. Inside Cit	
perilling in the Maryland A. I. I. 20000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "netural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be multibut at any injury or other traumatic.	by Funeral Director	Maryland   Anne  10e. Street and Number  829 Janice Driv  11. Marital Status		An An	unapolis	10f. Zip	1403	nic Origin	? (Specify Yes or N	Unit	n of What Cou	tes	
thours after of tan		1 Never Married 2 Marrie 3 WW Widowed 4 Divorced  15. Decedent's	If Yes, G Year or I	2 €No ive	16a. Dece	1 □ Yes 2 dent's Usua	No Sp	pecify:	? (Specify Yes or N uerto Rican, etc.)	S	Black, White, pecify: W	hite	
iled within 72 Hygiene. thar than "ne nt, the Wedle	Completed	(Specify only highest Elementary/Secondary (0-12)  8  17. Father's Name (First, Middle, L	grade completed, College	) (1-4or 5+)	(Give life.	kind of wor DO NOT us omemal	k done durin e retired) K <b>er</b>	g most of	working Name (First, Middle	own	home		
Tallylain  2 should be fand Mental be is marked of sumatic eval	To Be	William Davis  19a. Informant's Name/Relationshi	p (Type, Print)			-	L(Street and /	ola l Vum <i>ber</i> o	Blanche W	ard ber, City or 7	own, State, Zij	o Code)	
Pages 1 and fent of Health nt: If item 27 ry or other tr		Elsie L. Oliver  20a. Method of Disposition  1 Buriai 2 Cremation  4 Donation 5 Other (Sp.	3 □Removal from	20b.	Place of Dispo cemetery, crer	sition (Nam natory or ot	e of ther place)	1	Date 7. 10, 20	20c. Loca	tion - City or T		
permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service L  21. Signature of Funeral Service L  23a. Part1. Enter the disease, or of	t Kon	nusl	ú 14	2. Name and +7 Dul	Address of	Facility Gloud	John M.	Taylor . Anna	Funer	al Home	401
The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law required for use as the burial-transit  The law required for use as the law required fo	edicai Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	each line.	quence of):				disease			Interval Betwonset and E	Death
the death cert y the attending	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 250 No 9 ☐ Unknown	1 Live	atcome of pregr birth 2 ☐ Fel Inant at time of nown	tal death 3	Ectopic pre Other (spe				230	d. Date of deliv Month		/ear
w requires that the despensioned by the a	by	Part II. Other significant condition	s contributing to	death but not re	sulting in the u	nderlying ca	ause given in	Part I.		Yes 2 🗆	contribute to t	oably 4 📆 ⊌	Inknown
	Be Completed	25. Was case referred to medical examiner?							auto perf 1 □ Yes Death (Check only	ormed? 225No	prior to co death? 1  Yes	mpletion of ca	ause of
ding Phys	Certification; To	1 Yes 22No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could no	28a. Date (Moi	of Injury oth, Day Year)	ER/Outpatier 28b. Time of Injury	M 21	3c. Injury at Work? 1 ☐ Yes	_	ng Home → Res 28d. Describe	how injury o	occurred		
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determine determine 4 Homicide 29a. Certifier 1 Certifying	Physician: To th	e of Injury - At I ding, etc. (Spec	nowledge, deat	h occurred a	at the time, d	ate and pl	City or To	own, State) cause(s) ar	Number or Rura	stated.	
To the Ho within 24. To the Fu completed	Medical	(Check only 2 Medical E	and mai	basis of examin nner stated.		29c	License nur	mber	occurred at the time	29d. Date s	signed (Month,	Day, Year)	
		30. Name and address of person w	the completed cau		em 23a) (Type, /32	Print)	165	cŢ	9 svite	20	1 Anna	polis	MP
St Regist	ate rar	31. Date filed (Month, Day, Year)	9 2004	Restrar's Sign									

DHMH 17 Rev 1/2001

			For State Registrar	State o	f Maryla	and / Depa <i>Cel</i>	artment of F	lealth and i <i>Death</i>	Mental Hygier		37786
	Dhunisi		1. Decedent's Name (First, Middle, La	st)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Charles Edward C	adell,	Jr.					8 2004	2:37 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, giv				4b. City, Town, or	r Location of Deat	h	4c. County of Dea	ath
			Heritage Harbour  5. Social Security Number 6. S			rs. last birthday)	Annapo1			Anne Aru	
	Funeral Director		212-30-7549	X M 2□F	7. Age (iii y	Yrs. <i>Iasi birtilday)</i>	Months Days	Hours Min.		1934	rthplace (State or Foreign ountry)
Ь,			Usual Residence of Decedent		70				APILL O,	1734	Maryland
	rylan how		10a. State 10b. County		10c.	City, Town or Lo	cation				10d. Inside City Limits
	e Ma Sa-f s	cto	Maryland Anne A	runde1			Ann	apolis			1XXYes 2 □ No
	or 2	Dire	10e. Street and Number				10f. Zip Code		10g.	Citizen of What C	ountry?
	s 23a	rai	403 Riding Ridge		adam Franci	-110		403		nited St	
	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show the Modical Examiner must be notified at	by Funerai Director	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Dec	rces?		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	14. Race - Am Black, Wh	
920	urs af	by	3 ☐ Widowed 4 ☐ Divorced	1 MYes If Yes, Gir Year or D		954- 958	1□Yes 2∏ No	Specify:		Specify:	White
21215-0036	72 ho	Completed	15. Decedent's E. (Specify only highest gra	ducation		16a. Dece	dent's Usual Occup	ation	rking 16b	. Kind of Business	s/Industry
21	ithin ithin	npie	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	DO NOT use retired	during most of wor	King		
	led w lygier her th			2		La	b Manag <b>e</b> r				1 Academy
and	ntal H ad ot	Be	17. Father's Name (First, Middle, Last,		<b>a</b> .				me (First, Middle, Maid	len Sumame)	
Maryland	hould id Me mark matic	2	Charles Edward C.  19a. Informant's Name/Relationship (		or.	19h Mailir	ng Address (Street		L. Wirth ural Route Number, Cit	v or Town State	Zin Code)
<u>a</u>	nd 2 suith ar 27 is 27 is r trau		Madeline Cadell		e		3 Riding				ryland 21403
ē,	s 1 ar f Hea itam otha		20a. Method of Disposition	•	201	b. Place of Dispo	199			Location - City or	
E	Page nent c ant: If ury or		1 X Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif		State Hi			, I	12/2004 A	nnapolis	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itams 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		21. Signature of Funeral Service Lice	see			. Name and Addres				eral Home, In
B	89589		1/(ith) ()	ven						Annapoli	s, MD 21401
r			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that of one cause on e	aused the deach line.	eath. Do not ent	er the mode of dyin	g, such as cardiad	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Bro	ins co		with n	nets			6 montes.
	/Medical Examiner		Tooland in doubly	Due to	(or as a cons	sequence of):					
١,		er	Sequentially list conditions, if any, leading to immediate	b Due to	(or as a cons	sequence of):					
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	C							
o,	an an	Exa	resulting in death) Last	Due to	(or as a cons	sequence of):					
58760,	icate be executed physician and s the burial-transit	dicai		d							
		0	IF FEMALE:	Dan Huga au	anno of neo						
Вох	death certifii e attending p id for use as	ian/	23b. Was decedent pregnant in the past 12 months?		oirth 2 □ F nant at time o	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
o.	0 9 6	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unkn		JI GOALLI JL	Joiner (specify)				
Δ.	iaw requires that the as been signed by th 2 should be detacht	by Pr	Part II. Other significant conditions of	ontributing to d	eath but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tobacc	o use contribute t	o the cause of death?
Records,	w required been sign should be								1 ☐ Yes	2 □ No 3 □ P	robably 4 \Unknown
900	aw re	Completed							24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
Ä	The ate h page	Com							performed	death?	_
Vita	iclan: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	I I a series is					ath (Check only one)		
of	hys this al di	2	1 Yes 2 No			ER/Outpatien		4 Day Nursing F	tome 5 Residence		cify)
_	D Je	ion	1 Natural 5 ☐ Pending		th, Day Year		Worl	γaτ k? Yes 2□No	28d. Describe how in	jury occurred	
Division	Attending r death.  ctor: After by the fune	ertification;	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place			eet, factory, office		28f. Location (Street	and Number or R	ural Route Number,
ā	s after in Dire	Certi	4  Homicide	buildi	ng, etc. (Spe	ecify)			City or Town, Sta	ate)	
	To the Hospitet or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu	edical (	29a. Certifier 1 Certifying Ph	ysician: To the	best of my	knowledge, death	occurred at the tim	ne, date and place	, and due to the cause irred at the time, date a	(s) and manner a	s stated.
	the H hin 24 the F	Medi	one)	and man	ner stated.						
1	To To	<	29b. Signature and title of certifier	. 9			29c. License	ULVIA		Date signed (Mont	
7			20 Name and address of access in	nompleted	o of death "	tom (22-) /T =	Print)	(051)		1-8-0	
			30. Name and address of person who		IHO!	Modiac	n Parke,	Colen	Burene,	21061, 8	10
	Sta	te	31. Date filed (Month, Day, Year)							<u> </u>	*
	Registr	ar	NOV - 9	2004	Merc	gnatura	0845)				

			4 101	artment of Health and Me	•	ne
			Registrar  1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. N	2004 37787
**	Physici		Esther Diamond Cason		Month D	Pay Year 6:35P
-	/Medic Examir		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		2004 6:35P M
1			Washington Adventist Hospital	Takoma Park	M	Montgomery
	Funeral Director		5. Social Security Number  578-96-2242  G. Sex  1 M 2 KF  7. Age (In yrs. last birthday, find the second of the se	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 10/11/19	
	yland now		10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	a-fat	ctor	MD Montgomery Silver	Spring		1 ☐ Yes 2 ☐ No X
	or 28	Dire	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	ss 23g	erai	8305 12th Ave.  11. Marital Status 12. Was Decedent Ever in U.S. 13.	20903		S.A.  14. Race - American Indian,
98	be filed within 72 hours after death with the Maryland tal Hygiene. od other than "natural" or itams 23a or 28a-1 ahow avent, i're Medical Evar ii ve i'rissi be retified at	y Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 □ Xto	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 ☐ No Specify:	ican, etc.)	Black, White, etc.  Specify: Black
Ö	hours tural'	ed by	3 ☐ Widowed 4 12 Divorced Year or Dates:  15. Decedent's Education 16a. Dece	dent's Usual Occupation	16h	Kind of Business/Industry
21215-0036	hin 72 s. no "na Medio	Completed	(Specify only highest grade completed) (Give	a kind of work done during most of working DO NOT use retired)	7	Kind of Business/Industry
	filed with Hygiene. thar than	Com	12 Priv	ate Duty Nurse		Private
Maryland	be do do do do do do do do do do do do do	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (		an Sumame)
E Y	2 should be and Menta Is marked sumatic av	2	Ulysses Cason  19a. Informant's Name/Relationship (Type, Print)  19b. Mail	Addie Ve ing Address (Street and Number or Rural)		er Town-State Zin Code)
	nd 2 st lith ar 27 Is rtrau		Sedatrious Fields /daughter 380			er Spring, MD
Baltimore,	0 0		20a Method of Disposition 20h Place of Dispo	osition (Name of Damatory or other place)		Location - City or Town, State
ij	permit. Pages Department of I Important: If its any injury or o		`4 □Donation 5 □Other (Specify) Ft. Lin			ntwood, MD.
Bal	permil Depar Impor any ir			2. Name and Address of Facility Hoc 910 Silver Hill		
	4		23a, Part1. Enter the disease, or complications that caused the death. Do not en			Approximate
	Physician		Mock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition as a	ni Edan		Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			
		e	Sequentially list conditions, if any, leading to immediate b.	abod (asolic	myelse	thy
	outed id ansit	Examin	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		- 11	
90,	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):			-
68760,	icate b physic s the b	dicai	d			
Box (	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	7		23d. Date of delivery
	it the deatl by the atte tached for	Physician/Med		□Ectopic pregnancy □ Other (specify)		Month Day Year
P.0	that the sd by the detach		Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I	23e Did tobacco	use contribute to the cause of death?
Records,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	ted by				2 No 3 Probably 4 ⊋Unknown
Seco	e law re has be e 2 sho	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
alF	i <b>cian</b> : The l certificate ha rector, page		25. Was case referred to medical		performed? 1 ☐ Yes 2 ☐ N	death? 1 ☐ Yes 2 ☐ No
Vital	Physician: this certific ral director,	o Be	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2   EP/Outpatient	26. Place of Death (in the state of Death (in		6 ☐ Other (Specify)
n of	ding Ph h. After th funeral	on: T	27. Manner of Death 1 ★Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury		d. Describe how inju	
Sio	an or: he	cati	2 Accident investigation	M 1 Tes 2 No		
Division	al or Att s after de il Diract	Certification:	4 Homicide determined determined determined	eet, factory, office	f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)
	To the Hospital or a within 24 hours after To the Funaral Direct completely filled in b.	edicai (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in	n occurred at the time, date and place, and vestigation, in my opinion, death occurred	d due to the cause(s at the time, date an	s) and manner as stated. Id place, and due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of entifier	29c. License number		ate signed (Month, Day, Year)
•			) V ( ) V (	D 45660	)	1-10-04
	2		30. Name and address of person who completed cause of death (item 23a) (Type,	Print) LN 124, B	chie	MD 20711
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 3 0 2004  32. Registrar's Signature	South		

		·	1- For Amend Ite State Ragistrar		h <sup>of</sup> d8	38 <sup>1</sup> 9241	Depa Cer	rtment of tificate o	f Healtl	n and M th	Mental Hy	/gien	2004	ļ	377	88
	o Physici	an	1. Decedent's Name (First, Mi		F3 FX	DOTT					2. Date of D Month		15 20°C	ear	3. Time o	
	/Media	al	4a. Facility Name (If not institu	LLIE MAR				4b. City, Tow	a as Lagaria	an of Dooth	NOVEMB		15 200 lc. County of E		9:2	4 A <sup>M</sup>
	Examir	er	UPPER CHESAPEZ	-					BEL A			1	Í	ARFO	USI)	
	Funeral		5. S218-032-N7604	6. Sex	7. Ag	ge (In yrs. last bi	rthday)	If Under 1 Ye	ar If Und	ler 24 Hrs.	8. Date of B	rth You	9	Birthol	ace (State)	or Foreign
	Director		<del>218-32-7406</del>	1 □ M 2X	F	72	Yrs.	Months Da	ys Hour	s Min.	Feb. 2	9, 19	932	Vir	ginia	
	and w		Usual Residence of Decedent 10a. State 10b. Cou	nty		10c. City, Tow	n or Loc	cation						10	d. Inside C	ity Limits
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	th wit	ai D	1425 St	. Michael	ls Co	ourt		2	1040				USA			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant, If a Medical Erac, it at mind be rediffed at once.	by Funeral Director	11. Marital Status  1 Never Married 2 N  3 Widowed 4 Divor	Arme	Decedent d Forces? es 2 0 , Give or Dates:		lt lt	Vas Decedent o Yes, specify O ☐ Yes 2X	uban, Mexi	can, Puerto	pecify Yes or N Rican, etc.)	0-	14. Race - A Black, V Specify:		itc.	
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2	ithin 7 19.	nple	Elementary/Secondary (0-1	hest grade comple 2) Colle	ge (1-4or	5+)	life. D	kind of work do OO NOT use re	tired)	iosi di won	king					
	ited w lygier ther th	Co	17. Father's Name (First, Midd				L	omesti		thor's Nor	ne (First, Middle	1	Private	Но	mes	
anc	d be f antal h sed of	o Be	Frank Brown	ie, Lasi)						_	rollive		<i>in Surra</i> me)			
Maryland	shoul nd Me mark	J.	19a, Informant's Name/Relati	enship (Type, Print)		198	o. Mailing	g Address (Stre			rai Route Numi		or Town, Sta	te, Zip	Code)	
	and 2 valth a n 27 is		Barbara Turner	/ Daught	er	1	425	St. Mic	chaels	ct.	, Edgew	ood,	MD 21	040		
ore	of Healt of Healt if itam 2		20a. Method of Disposition 1 X Burial 2 □ Crematic	n 3 ⊟Removalf	rom State	20b. Place o	of Dispos ory, crem	sition (Name of natory or other)	olace)		Date	20c. I	Location - City	y or Tov	vn, State	
Baltimore,	Pag tment tant: jury c		`4 □Donation 5 □ Other	(Specify)	om otato	Harfo		Memoria.			/19/04	Ab	erdeen	, M	aryla	nd
Bai	permit Depar Impor any in		21. Signature of Funeral Serv	-Scott			1	Lisa 552	Scott ewis	: Fune Stree	eral Ho	ne, re'd	P.A. le Grac	e,	VID 21	
	Physician		23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	ist only one cause	on each li	ne.	-	CEPH:				arrest,			Approximat Interval Bet Onset and	ween
	/Medical Examiner		Sequentially list conditions	b. Du	TYP	a consequence	1								241	HRS
l	uted t insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>4</b>	AR	a eonsequaries     √	A (	00	NCE	= R					1 Mc	NTH
<b>o</b>	tificate be executed ig physician and as the burial-transit		that initiated events resulting in death) Last	c	to (or as	a consequence	of):		11000	-10					, , , , ,	/10 (01
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_	ertific ding p		IF FEMALE:	220 16 400	autoomo	of areas										
P.O. Box	Attending Physician: The law requires that the death certif of the control octain.  octor: After this certificate has been signed by the attending better: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 □ L 4 □ P	ve birth	of pregnancy 2  Fetal death t time of death		Ectopic pregna Other (specify,					23d. Date of Month			Year
	s that ined b e deta	by Pl	Part II. Other significant cond	itions contributing	to death b	out not resulting i	n the un	derlying cause	given in Pa	rt I.	23e. Did	tobacco	use contribut	te to the	cause of c	leath?
ğ	w require been sig should b										1 🗆	Yes 2	2□No 3□	Proba	bly 4 😿	Jnknown
Division of Vital Records,	ysician: The law n is certificate has be director, page 2 sh	Completed									24a. Was auto perf 1 \( \text{Yes}		prior deat	to com	sy findings pletion of c	available ause of
Vita	ilcian: Th certificate rector, pag	Be	25. Was case referred to med examiner?	cal Hospital:					Othor		h (Check only					
ō	Phys	2	1 ☐ Yes 2 No  27. Manger of Death		Inpatie		utpatient Time of	3 DOA		Nursing Ho	ome 5 Res			Specify)		
on	ding th. : After fune	tion	1 Natural 5 ☐ Per	ding (	ate of Inju Month, Da	y Year)	Injury		njury at Vork? Yes 2	□No	200. 0030.00	now my	ary occurred			
N	Atter or dea octor by the	ertification:	3 ☐ Suicide 6 ☐ Cor	ld not be 28e. P	lace of Inj	jury - At home, fa	arm, stre	et, factory, office	ce		28f. Location			r Rural	Route Num	ber,
ā	tal or rs afte al Dire	Cert	4   Hornicide		uilaing, ei	tc. (Specify)					City or To	wn, Stat	re <i>)</i>			
	To the Hospital or Attending Phwithin 24 hours after death. To the Fineral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certi (Check only one) 2 Medi	ying Physician: To al Examiner: On the and	the best ne basis o nanner st	f examination ar	e, death nd/or invi	occurred at the estigation, in m	time, date y opinion, d	and place, leath occur	and due to the red at the time,	cause(s date ar	s) and manne nd place, and	r as sta due to	ted. the cause(s	·)
	To tha within 2 To tha complet	Σ	29b. Signature and title of cer	ifier	,	- (			ense numbe				ate signed (M			
			parice	a gu	ru	Mo			63	44		1001	JEMBE	=K	15,2	.004
_	\		30. Name and address of pers	GURNY	mi	D U	OPER	2 Cits	SITP	EAKE	MEDIC					
5	Sta Registr	-	31. Date filed (Month, Day, Ye NOV 1	7 2004	2. Registr	rar's Signature	Sp	anti.								

Maria

Dorsey, Lillie

			1 = For State Registrar		f Marylar	•	artment rtificate			ind M	lental Hyg	iene	004	377	89
п	Physici	an	1. Decedent's Name (First, Middle								2. Date of Deat Month	Day	Year	3. Time o	of Death
	/Medic	al	Peter W. Diss 4a. Facility Name (If not institution		mber)		4b. City. 1	Town or	Location o	f Death	Novembe		2004 County of Dea	8:30	_ A
1	Examir	er	Heritage Harbou	-				apol					_	rundel	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under Months		If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Bir	thplace (State	or Foreign
	Director		182-24-6710 Usual Residence of Decedent	1 <b>X</b> M 2□F	77	Yrs.		24,0			3-19-1			nsýlva	nia
	ow A		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside 0	City Limits
	a-fsh	ţċ	Maryland Anne	Arundel	S	Shady S	ide							1 □ Yes	2 X No
	or 28	Dire	10e. Street and Number				10f. Zip	Code			1	-	en of What C	ountry?	
	s 23a	erai	1194 Maple Ave		edent Ever in U	16 112	Man Daned			20764		USA	4. Race - Am	oriona ladina	
(0	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural; or items 23a or 28a-f show aumatic event, the Modical Extrainment aumatic event, the Modical Extrainment	Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Marr	Armed Fo	rces?	1.5.				, Puerto	ecify Yes or No- Rican, etc.)	'	Black, Whi		
5-0036	rai, o		3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi Year or D	2 □ No ve pates:1945-	-46	1 ☐ Yes 2	XX <sub>N</sub> o	Specify:				Specify:	White	
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d 2	illed Hygie other	Be Co	17. Father's Name (First, Middle,		112	1101	uarc			r's Name	(First, Middle, I			Deole	
ılan	Aental Aental rked c	To B	Hamilton D	isston					ű	Jessi	le Willi	amsc	on		
Maryland	2 should and Men is marke sumatic		19a. Informant's Name/Relations	-							l Route Number	•		Zip Code)	
	l and leelth om 27 sher tr		Mary D. McHenr 20a. Method of Disposition	y/ Sister		1194			e., S		Side,		20764 ation - City or	Town State	
5	nt of h		Burial 2 Cremation		State St.	cemetery, crei	natory or ot	her place	e)   rv   1	1_11	-04		,	ngton, 3	ΣΔ
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examilinet is ust be notified at once.		*4 □Donation 5 □ Other (S						_ 1		orge P.				
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8760,	cate be executed / Medician and / Medician and ithe burial-transit	dicai Examiner	shock, or heart failure. List tmmediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	(or as a consector as	quence of):	blee	lin	9	こい	A			Onset and	Death
O. Box 6	ath certific titending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live I	tcome of pregna pirth 2 ☐ Feta nant at time of c own	aldéath 3[	⊒Ectopic pre ⊒ Other (spe					23	3d. Date of de Month		Year
rds, P.	w requires that the de been signed by the a should be detached f	b	Part II. Other significant condition	ons contributing to d	leath but not res	sulting in the u	nderlying ca	use give	on in Part I.		23e. Did tob	_		o the cause of robably 4	
Il Records,	ίο <u></u>	Completed			•		· · · · · · · · · · · · · · · · · · ·				24a. Was a autops perform 1 \( \text{Yes} \) 2	v l	24b. Were a prior to death?	utopsy findings completion of c	available cause of
Vital	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	· ·		(Check only on				
o	this al div	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin 2 Accident investignment	28a. Date g (Mon	Inpatient 2 Control of Injury (th, Day Year)	ER/Outpatier 28b. Time o Injury		Bc. Injury Work	4130190		ne 5 Reside 28d. Describe ho			ecify)	
Division	is gird	Certification:	2 Accident INVestig	not be 28e. Place	e of Injury - At h ing, etc. (Specia	ome, farm, str fy)	reet, factory,			-	28f. Location (St. City or Town		Number or R	ural Route Nun	nber,
	he Hospitai n 24 hours e he Funerai t pletely filled	edical	29a. Certifier (Check only one)  Certifyin  Certifyin	g Physician: To the Examiner: On the b and man	e best of my kno easis of examina oner stated.	owledge, deat ation and/or in	h occurred a vestigation,	at the tim in my op	e, date and pinion, deat	d place, a	and due to the ca	iuse(s) a ate and p	and manner as place, and due	s stated. e to the cause(	s)
	To the within 2 To the complet	Ň	29b. Signature and title of artifie		in n		29c.	~	number	<i></i>	- 4	d. Date	signed (Moni	th, Day, Year)	
•				10	111		$\nu$	U	024	7	//	1/0	8/04		
			30. Name and address of person	who completed cau. 1655 Cro				Λ1	Chart		MD 0441		,		
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	Regist		NOV - 9	2004	ma le	13	who								

State of Maryland / Department of Health and Mental Hygie pen n L For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Katherine Olivia Dickens **Physician** 19, 2004 3:30ам Nov. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Manchester Long View Nursing Home If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 3/17/1915 9. Birthplace (State or Foreign **Funeral** Months 213-28-8541 1 □ M 2 □ X € Maryland Director Usuel Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location or Items 23a or 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar anent of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or items 23a or 28e-f show up yor other fraunatic event, it a M. siral Examine must be collined as uny or other fraunatic event, it a M. siral Examine must be collined as Carroll MD Manchester 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3332 Main Street 21102 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Nurse's Aid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mae Tracey Eli Tracey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2509 Mt. Ventus Rd., Manchester, MD 21102 Kyle E. Dickens 20b. Place of Disposition (Name of cometery crematory or other place)
Mt. Zion United Methodist Cem. Date 22, 20a, Method of Disposition 20c. Location - City or Town, State Nov. 2004 Department of H
Important: If ite
any injury or of
once. ₩DBurial 2 Cremation 3 Removal from State Freeland, MD 4 Donation 5 Other (Specify) 21. Sign at 19 of F negal Pervice Lensee permit. 22. Name and Address of Facility J.J.Hartenstein Mortuary, Iric 24 Second St., New Freedom, PA 17349 Approximate Interval Between Onset and Death whe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest eart failure. List only one cause on each line. Immediate Cause (Final disease or condition Priysician End Stage resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate the control of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, cate has been signed by the attending physicien page 2 should be detached for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No 2 X No 1 Tes or Attending Physicien: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 1 ☐ Yes 2 X No 2 ER/Outpatient 4 X Nursing Home 5 Residence 6 Other (Specify) Certification: To 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide To the Hospital filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 51705 70 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) estminstel M. PANSURI Mallolm 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar MAY 3 0 2004

			For State Registrar	* -	aryland / Depa		lealth and M	lental Hyg	9		37791
	Physici /Medic		1. Decedent's Name (First, Middle William Thomas					2. Date of Dea Nov 17	04 <sup>Day</sup>	Year	3. Time of Death 4:47AM M
	Examin		4a. Facility Name (If not institution, 217 Pear Stree			4b. City, Town, o Cumber	r Location of Death Land		4c. County A11	of Deeth	
	Funeral Director		725-09-1054	1□M 2□F	ge (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan 15,	, Year) 1926	9. Birthp Court	lace (State or Foreign try)
	ryland thow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo					1	Od. Inside City Limits
	the Ma	recto	MD Alleg	any	Cumb	erland			10g. Citizen of \	What Cour	Yes 2 No
	th with 23a or	al Di	217 Pear Street				21502		US		,
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mealth Hygiene. If Health and Mealth Hygiene. Other traumatic event, the Medical Exam, is constituted at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 1 Divorced	12. Was Decedent Armed Forces of 1 Yes 2 In Market Forces in Market Parket No	Was Decedent of H f Yes, specify Cube 1 Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac Blac Specify	e - Americ ck, White,	etc.	
15-0	n 72 ho "natur edical	oleted	15. Decedent (Specify only highes	grade completed)	16a. Decec (Give life.	dent's Usual Occup kind of work done	oation during most of work d)	ing	16b. Kind of Bu	usiness/Ind	dustry
212	filed within Hygiene. sther than "	Comp	Elementary/Secondary (0-12)	College (1-4or	5+)	ial officer		1	Northwe		ancial
Ĕ	Should be filt and Mental Hy Is marked oth	To Be	17. Father's Name (First, Middle, L William Thom	as Dillon, Sr.				Waters	Dillon		
Mar	nd 2 sh alth and 27 Is rr r traum		19a. Informant's Name/Relationsh Mike Dillon	ip <i>(Турө, Print)</i> <b>SON</b>		ng Address <i>(Street</i> ) 2 Mohican	and Number or Run Drive	Melbo	-	State, Zip	32935
Baltimore,		200000	20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 □Removal from State	20b. Place of Dispo		(8)	Date	20c. Location -	-	
ltim	그 문문 등		' 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		Scarpelli Fur			11/18/2004	Cresap	town	MD
Ba	Depa Impo any ir once.		Crame	57A	elui	Scarpelli 108 Vira	ss of Facility i Funeral Ho inia Avenue	me, PA : Cumberl	and, MD 2	21502	
			23a. Part1. Enter the disease, or shock of heart failure. List of the shock for the sh	complications that cause only one cause on each I cteriosclero	d the death. Do not ent ine.	er the mode of dyin	ng, such as cardiac	or respiratory arr	rest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	_ a	a consequence of):	Disease					uk yrs
	Examiner	-	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequence of):						
M	cuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c							
3760, 3	cate be executed chysician and the burial-transit	cai Ex	resulting in death) Last	Due to (or as	a consequence of):						
. Box 6	death certific e attending p od for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Dat	e of delive	ry Day Year
rds, P.	The law requires that the ste has been signed by th page 2 should be detache	by	Part II. Other significant condition Asthmatic	ns contributing to death t bronchitis	out not resulting in the u	nderlying cause giv	en in Part I.			A.II	e cause of death?
		Completed						24a. Was a autops perform	gy med?	rior to con leath?	osy findings available npletion of cause of 2 No
Vital	ician: certific rector,	o Be	25. Was case referred to medical examiner?	Hospital:	ent 2□ER/Outpatien	oth	26. Place of Deatler: 4 □ Nursing Ho				
of		-	27. Manner of Death Natural 5 Pending	28a. Date of Inju	ury 28b. Time of	28c. Injun World	4 □ Nursing Ho y at k?	28d. Describe h			")
Division	Atten r deat ector: by the	Certification	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of In	jury - At home, farm, str.		Yes 2 □ No	28f. Location (Si City or Town		er or Rura	l Route Number,
ā	To the Hospital or within 24 hours after To the Funeral Diracompletely filled in It.		29a. Certifier 1 ☐ Certifying	Physician: To the best	of my knowledge, death	occurred at the tin	ne, date and place,	and due to the c	ause(s) and ma	nner as st	ated.
	To the He within 24 To the Fu complete	Medical	(Check only one)  29b. Signature and title of certifier	xaminer: On the basis of and manner st	ated.	29c. Licenso			ate and place, a		
	F × 5 8		) ( A. l	1			9157		Nov 17		oay, reary
-	2			the completed cause of the completed cause of the completed cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the complete cause of the		-	1 1 1	W1 0155			
37	Sta	ite	Paul Snow, M. 1 31. Date filed (Month, Day, Year)	D. Dpty Med 32. Regist	EX 124 W	4 %	umberland	Ma 2150	12		
7	Registr	ar	NOV 3 0	2004 5	neva &	Spark	2				

			1 - For State of Maryland / Dep  Registrar Ce	artment of Health and M rtificate of Death	ental Hygier	2004	37792
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Gladys  Ennis		2. Date of Death Month	200 2002	3. Time of Death 5:20 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	ith
			6123 Parkwood Rd  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Cheverly  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Prince Ge	
	Funeral Director		113-22-1140  1	Months Days Hours Min.	(Month, Day, Yea	ar)   C	thplace (State or Foreign ountry) 1th Carolina
	and		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation			10d. Inside City Limits
	a-f sho	ctor	MD Prince George's Cheve	rly			1 ☑ Yes 2 ☐ No
	with the	Funeral Director	10e. Street and Number	10f. Zip Code		Citizen of What C	ountry?
	ns 23	erai	6123 Parkwood Road  11. Marital Status 12. Was Decedent Ever in U.S. 13.	20785 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto		.S.A.	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evantral must be reallised at ODGe.	b	Armed Forces?  1 ☐ Never Married 2 ☐ Married	If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Specify: Na	
2-0	72 ho natura	eted	(Specify only highest grade completed) (Give	edent's Usual Occupation  a kind of work done during most of worki	ng 16b.	. Kind of Business	
21215-0036	within lene. than '	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) se Assistant		Priva	ate
nd	al Hygi al Aygi a other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	len Sumame)	
Maryland	d Ment marked matic	<sup>L</sup>	Reed Johnson  19a. Informant's Name/Relationship (Type, Print)  19b. Mail	Ada	I Pouto Number Cit	Jackson	Zio Codo)
Z S	nd 2 sl alth an 27 ls r ir traur			B Parkwood Road Ch		*	
Baltimore,	ges 1 a t of Hea If item or othe		1   Burial 2 X Cremation 3   Removal from State	matory or other place)		Location - City or	
亞里	artment ortant: injury			e Crematory $11/14$		erdale,M	
Ba	Depa Impo			7474 Landover Road			
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a Congestive Heart		r respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):  Aterial Fibrillat	ion			
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exercise)  Peripheral vascul	ar disease			
8760,	death certificate be executed e attending physician and d for use as the burial-transit	ai Exar	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
9	tificate ig phys as the	ledic	o				
O. Box		Physician/Medicai		Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
صّ	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute t	o the cause of death?
ord	w require been sig should b	ted	Hypertension		1 🗆 Yes	2 □ No 3 □ P	robably 4 <del>€</del> Unknown
Vital Records,	The far ate has page 2	Completed			24a. Was an autopsy performed′ 1 ☐ Yes 2X	prior to death?	utopsy findings available completion of cause of 2 ₩ No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death		0.5304 (0.	
n of	ng Phy ter this neral d	on: To	27. Manner of Death 1 SZ Natural 5 Pending (Month, Day Year) Injury	HL 3L DOA 4L Nuising Ho	ne 5 Residence 28d. Describe how in		city)
Division	Attending r death. ector: After by the fune	icatio	2 Accident investigation 3 Suicide 6 Could not be as Bloom of Injury At home farm of	M 1 Yes 2 No	28f. Location (Street	and Number or R	ural Route Number
<u>&gt;</u>	al or A s after il Direct	Certification:	4 Homicide determined building, etc. (Specify)	neet, ractory, office	City or Town, St		ovar ricote riconoci,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, dea (Check only one)  Certifying Physician: To the best of my knowledge, dea (Check only one)  Medical Examines: On the basis of examination and/or in and manner stated.				
<b>)</b>	To the h within 24 To the F	M	29b. Signature and title of certifier	29c. License number		Date signed (Monitor)	
R	- H)		30. Name and address of erson who completed cause of death (Item 23a) (Type James Elmore M.D. 10403 Hospital D				
	Sta		31. Date filed (Month, Day, Year) . Registrar's Signature-		nton, riary	rand ZU/	J.J
	Registr	ar	NOV 1 6 2004 Reduce & April	W .			

Amend Item 29d per Dr., G842, U4/26/05dhb Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Foster-Moore November 13 2004 9:20 A Malvinia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Prince George's Hospital Cheverly If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🖾 F 1940 North Carolina Director 579-64-7622 64 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic svent, It a Medical Examiner must be multiple at 28a-f show tyE Yes 2 □ No Landover Hills Director Prince Georges 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20784 4008 Warner Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify **Black** 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker Government 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Allen Johnsie John W. Allen ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4008 Warner Avenue Landover Hills, Maryland 20784 Charles Moore/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 11/19/04 Washington, DC \* 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licenses 7474 Landover Road Landover, Maryland 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio Vascular Disease Pnysician /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown as been si 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Chronic Renal Failure 24a. Was an Jas autopsy this certificate ha performed? 1 🗌 Yes 2/2 No 1 Yes 20 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 🖾 No 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 SINatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year)/13/04 and this of certifier 29c. License number 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reavathy Murphy M.D. 6130 Landover Road Cheverly, Maryland 20785 31. Date filed (Month, Day, Year) State NOV 1 6 2004 Registrar

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	State of Maryland / Department of Health and Mental Hygien 00 4	< 1	1 4	114
	State of Marviand / Department of Health and Mental Hydiene 1111 44		1 )	-
		9 1	, -	

			1 - For State Registrar	State of Mi	arytaria / i		tificate of	Death		Reg. No.		01134
	o Dhanis		1. Decedent's Name (First, Middle, La	st)					2. Date of Dea	ath Day	Year;	3. Time of Death
	Physici /Media		John titzge	raid Jr	•				NOV	08	2004	0739 AM
	Examir	ner	4a. Facility Name (If not institution) giv	e street and number)	A 1		4b. City, Town, o	r Location of Death		4c.	County of Deat	th
			5. Social Security Number 6.5	nd Medical	e (In yrs. last bi	rthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	<u> </u>	10/17	thplace (State or Foreign
	Funeral Director			M 2□F	82	Yrs.	Months Days	Hours Min.	(Month, Day	y, Year)	Co	ountry)
	D		Usual Residence of Decedent		,				NOV. 23	, 13	ZI Wasi	nington, DC
	anylar Bhow	_	10a. State 10b. County		10c. City, Tov	m or Loc	cation					10d. Inside City Limits
	Ba-f	ecto	Maryland Montgor	nery	Sil	ver	Spring					1 ☐ Yes 2 ☑ No
	with ti	D.	10e. Street and Number 10621 Ordway Dri	***			10f. Zip Code 20901				zen of What Co	untry?
	leath ns 23	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	1	lispanic Origin? (Sp	ecify Yes or No-		SA 14. Race - Ame	arican Indian.
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "natural", or items 23a or 28a-f show importent: If item 27 ie marked other then "natural", or items 23a or 28a-f show any injury goother traumatic event, if a Medical Eventil at reast be ricilified at once.	by Funeral Director	1 ☐ Never Married 2 € Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces? 1 ∑Wes 2 □ I If Yes, Give Year or Dates:	No	1	Yes, specify Cuba  ☐ Yes 2點 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Black, White Specify: Whi	
2-0	72 ho	ted	15. Decedent's E (Specify only highest gra		16a	. Deced	ent's Usual Occup	pation	cina	16b. Kii	nd of Business/	/Industry
21215-0036	permit. Pages 1 and 2 should be filed within 'Department of Health and Mental Hygiene. Importent: If item 27 Ie marked other then "any injury contrer traumatic event, If a Mee. once.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		oo NOT use retired eman	during most of work d)	ang	U.S	. Gover	nment
	e filed al Hygid I other vent, t	Be C	17. Father's Name (First, Middle, Last	)				18. Mother's Nam	e (First, Middle,	Maiden	Surname)	
yla	should be ind Mental I marked o	2	John D. Fitzger	ald, Sr.				Madge	McMilla	n		
Maryland	2 short and lem		19a. Informant's Name/Relationship (	** *				and Number or Rur				
	1 and Health em 27 ther tr		Frances D. Fitzg	erald/ Wif		0621 of Dispos	Ordway I	Drive, Si	lver Sri		MD 20 cation - City or	
Baltimore,	Pages nent of H		1 🖾 Burial 2 □ Cremation 3 □				sition (Name of latory or other place Heaven	111000	mber 11			
薑	nit. Partme		<ul> <li>4 □ Donation 5 □ Other (Special</li> <li>21. Signature of Funeral Service Lices</li> </ul>			emet	erv	ss of Facility				ing, Marylan
Ba	permit. Departr Import eny inj			\$\frac{1}{2}\langle \langle	FT:	ncis J. Ju Univer	ss of Facility Collins csity Blv	Funeral d, w, S:	Home:	e Inc r Sprin	g, MD 20901	
			23a. Part1. Enter the dis shock, or heart failure. List only	plications that caused one cause on each li	i ti a ceath. Do						110	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Store								Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):						
	_Adimioi	<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	of):						
	ited	i i	Cause (Disease or injury	250 to (0. 00	2 30/130420/130	01/.						
Ć,	tificate be executed ig physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):						
68760,	te be ysicia ne bur			_ d								
	ntifical ng ph	Medicai	IE ECHAL C.			-						
.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician//	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	/		2	3d. Date of deli Month	ivery Day Year
<b>Q</b>	that	y Ph	Part II. Other significant conditions	contributing to death b	ut not resulting i	in the un	derlying cause giv	en in Part I.	23e. Did to	bacco u	se contribute to	the cause of death?
Records,	quires n sign ald be	d by							1 □ Y	'es 2[	□No 3□Pr	obably 4 Unknown
00	aw requir as been si 2 should	Completed							24a. Was		24b. Were au	itopsy findings available completion of cause of
R	The lav	E							autop perfor 1 ☐ Yes	rmed? 2 Z No	death?	
Vital		BeC	25. Was case referred to medical examiner?					26. Place of Deat				
of V	Physicien: this certific ral director,	P	1 □ Yes 2x No	Hospital: 1 Inpatie				4   INDISHING HO	ome 5 Resid			cify)
n c	ding Ph h. After th funeral	jon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		Time of Injury	28c. Injur Wor		28d. Describe h	low injury	occurred /	
isio	Attending r death. ector: After by the fune	icat	2 Accident investigatio 3 Suicide 6 Could not b	e 290 Place of Ini	uny - At home fo	arm etra		Yes 2 □ No	28f Location /S	Street and	Number or Pu	ural Route Number,
Division	after Direct	Certification:	4 Homicide determined	building, et	c. (Specify)	ziiii, 300	et, factory, office		City or Tow			rai riodie railibei,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edicai C	29a. Certifier 1X Certifying Ph (Check only 2 Medical Example)	nysician: To the best miner: On the basis o	of my knowledg	e, death	occurred at the tir	ne, date and place,	and due to the o	cause(s)	and manner as	stated.
	the hin 24 the f	Medi	one)	and manner sta	ated.							
	To vit	-	29b. Signature and title of certifier	in Mi			29c. Licens	number	-		signed (Month	,
l	0+1		ana Saveru	4 MD	onth /http://doi.org/	/Tr	P1-	1101		IV	DV 8	2004
			30. Name and address of person who Am Sanche7 MD	22 South	ORLA	U S	Street A	Balhmore	MD	21	201	
•	Sta Registi		31. Date filed (Month, Day, Year) NOV 1 2 20		ar's Signature	5	loo V	7				
	· negisti	reit .	1.00 - L N LUI	T	_	,	regionary					

			State Amend Item	8 per FH,G	ryland / Da 838,12/2	epartment of F	Death	Reg	ene 2004	37795
	Physici /Medio	al	1. Decedent's Name (First, Middle, Las  Sara Dill F  4a. Facility Name (If not institution, give	oquell		4b. City, Town, o		Date of Death Month	Day Year  10, 2004  4c. County of Death	3. Time of Death
	Examin Funeral Director		Chester River 5. Social Security Number 6. Security Number 216-18-2458	Hospite	(In yrs. last birth 81 Y	day) If Under 1 Year Months Days	ster tow	Date of Birth (Month, Day)	Ker	place (State or Foreign ntry)
	show		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town					10d. Inside City Limits
	or 28e-f	Directo	MD Kent  10e. Street and Number  300 Princess Ann	o Drivo	Cheste	ertown 10f. Zip Code 21620		_	g. Citizen of What Cou	1 X Yes 2 □ No ntry?
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hygiene. ortant: If item 27 is marked other than "netural", or items 23a or 28e-f show injury or other traumatic event, the Medical Examinar must be recitied at injury or other traumatic event, the Medical Examinar must be recitied at e.g.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 XN If Yes, Give Year or Dates:		13. Was Decedent of h	dispanic Origin? (Spectan, Mexican, Puerto Ric Specity:	y Yes or No-	14. Race - Ameri Black, White, Specify: Wh:	etc.
21215-0036	within 72 hou ene. than "netura he Medical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5-	(	Decedent's Usual Occup Give kind of work done life. DO NOT use retire	pation during most of working d)	16	b. Kind of Business/Ir	ndustry
	filed with Hygiene other thai	Be Con	12 17. Father's Name (First, Middle, Last)			ninstrative	Assistant 18. Mother's Name (			/Aricultur
Maryland	hould be d Mental marked c matic eve	ToB	Harry Scotten  19a. Informant's Name/Relationship (7)	ivne Print)	19h J	Mailing Address (Street	Mary Eliza			n Code)
	1 and 2 sho Health and Iom 27 is mother traum		Franklin M. Dill	ype, rivity	24	4530 Porter	s Grove Roa	ad, Wort	ton, MD 216	678
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or othar to once.		20a. Method of Disposition  1 □ Hurial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify		cemetery,	Disposition (Name of crematory or other place Cemetery	ce)		oc. Location - City or T Chestertown	
Balt	permit. Departimport any inj		21. Signature of Funeral Service Licenta	Pell 6	20		elfenbein a			Home, P.A.
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.O. Box 68	that the death certifica ed by the attending ph detached for use as th	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1	2 Fetal death	3 Ectopic pregnancy	,		23d. Date of deliv Month	ery Day Year
<u>α</u>	ed ngi	ed by Pr	Part II. Other significant conditions of	= .	•	he underlying cause giv	en in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
Vital Records,	s b	Completed	•					24a. Was an autopsy performe	prior to co death?	opsy findings available impletion of cause of
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of	Phys	H 1	27. Manna of Death  1 Natural 5 Pending	1 / Inpatier 28a. Date of Injur (Month, Day	v 28b. Tir	ne of 28c. Injury	y at 286	d. Describe how	ce 6 Other (Special injury occurred	<u>"</u>
Division	ad ad	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined		ry - At home, farr	M 1	Yes 2 No 281	Location (Stree City or Town,	et and Number or Rur State)	al Route Number,
J	Hospita 4 hours Funeral tely filled	edical Ce	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of the basis of and manner sta	examination and	death occurred at the tir for investigation, in my o	me, date and place, and pinion, death occurred	d due to the caus at the time, date	se(s) and manner as s e and place, and due t	stated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and tile of certifier			29c. Licens			1. Date signed (Month,	
			30. Name and ordress of person who	completed cause of de	eath (Item 23a) (T	ype, Priat)	066301		11/11/01 TEXTOUR	
÷	Sta	ate	M CGARCI PET 31. Date filed (Month, Day, Year)		ir's Signature	- Show k	D 5165	CHES	TENTOWN	, nd
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			For State Ragistrar	Sta	ate o	f Maryla	nd / Dep <i>Ce</i>	artme e <i>rtifica</i>	nt of H	ealth a D <i>eath</i>	ind M	ental H	ygiei Reg.		Ļ	377	96
Profession of the Control of the Con			1. Decedent's Name (First, Middle	, Last)								2. Date of I		Day	Year	3. Time of D	Death
	Physicia		Edward James G	reene										7, 200		4:00	ам
	/Medic Examin	- 43	4a. Facility Name (If not institution	, give street	and nur	nber)		4b. Cit	y, Town, or	Location of	f Death			4c. County o	f Death		
			Suburban Hosp	ital				Ве	thesd	a				Montgo	omer	V	
3	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs		/) If Und Month	er 1 Year s Days	If Under 2 Hours	24 Hrs. Min.	8. Date of I	Birth Day, Ye			lace (State or	Foreign
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	P.		Usual Residence of Decedent			100 0	ity, Town or l	continu							1	Od. Inside City	v Limits
	urylar show	<b>L</b>	10a. State 10b. County			100.0	ity, rown or t	Location								1 ☐ Yes	
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	be filed within 72 hours after death with the Marylan ital Hygiene. Ind other than "natural", or Items 23a or 28a-f show avent, the Medical Examiliser must be natified at	Funeral	11. Marital Status 1 □ Never Married 2 □ Marr	ied ty	med Fo	2 🗆 No					gin? (Spe , Puerto l	ecify Yes or Rican, etc.)	No-	Black	, White,	can Indian, etc. ite	
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and	be fi	Be										, , ,			•		
Ž	2 should be and Mental Is marked raumatic av	2	Edward James  19a Informant's Name/Relations				10h Ma	ilina Addre	es (Street s			Hellem		ty or Town, S	State Zir	Code)	
Z	12 st n and 7 ls n raun		Kathleen Godfre			er		-						per, V			
a)	l and Healtl	1 7	20a. Method of Disposition	77 - 40			Place of Dis	nocition (A	lame of		Ď	Date	200	. Location - C	_		
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	-		23a. Part 1. Enter the disease, or shock, or heart failure. List	complication	ns that o	caused the de	ath. Do not e	nter the m	ode of dyin	g, such as	cardiac c	or respirator	arrest,			Approximate Interval Betw	veen
27	Physician		Immediate Cause (Final				D									Onset and D	eath
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g	uires sigr ld be	d by	Parkinson's D	isease	e, D	ementi	a, Hyp	erten	sion			1	☐ Yes	2 🗆 No	3 🗌 Prof	bably 4 🖼	nknown
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ot o	Physician: r this certifica ral director, I	6	1 Yes 2 No		1 25	Inpatient 2	1		DOA 28c. Injun	4 🗀 190				e 6 Dothe		ny)	
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[			30. Name and address of person	who comple	eted cau	ise of death (I	tem 23a) (Typ	e, Print)									
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	St Regis	tate	31. Date filed (Mohth, Day, Year NOV 1 2		32.	Begistrar's Sig		A	acks	/							
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GREENE, EDWARD 11/104 0400AM

State of Maryland / Department of Health and Mental Hygier State State Registra/MEND#31, See#32, 11/12/04, BW, MoCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NOVEMBER 7 2004 ANTONIO AUGUSTIN GIANNICO 1:15 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NATIONAL INSTITUTES OF HEALTH **BETHESDA** MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**√**2 M 2 □ F 100-28-7994 66 Director 1/07/1938 Yonkers, N. Y. Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at N.Y. Schiare Jefferson 1 ∏Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12093 USA 153 Stannard Road Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 → Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White δ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Contractor Construction permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygie.
Important: If item 27 is marked other tt
any injury or other traumatic event, that 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Gallo Angelo Giannico 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Giannico/Wife Jefferson, New York 12093 153 Stannard Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date St. Joseph S Cem. 1 ➡ Burial 2 □ Cremation 3 □ Removal from State

• 4 □ Donation 5 □ Other (Specify) 11/12/04 Yonkers, New York 21. Signatur of Funeral Servic Lic nseg PHILIP D. KINALDI FUNERAL SERVICE, P.A. Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Priysician 10 monthis /Medical Jue to (or as a consequence of): Examiner Sequentially its conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown been si should 24a. Was an 24b. Were autopsy findings available within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s performed? death? 1 ☐ Yes 2 ☐ No 2□No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 2 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 010110255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CENTER DRIVE, BETHESDA, MARYBETH HUGHES MARYLAND 20892 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

NOV 13

**ZUU4** 

NOV 1 2 2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November 11, John Clayton Gilbert 2004 0400 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Laurelwood Care Center E1kton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 19,1924 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F Vermont 008-12-3220 80 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow traumatic avant, the Medical Examiner must be notified at 1X Yes 2 No Director New Castle Middletown Delaware 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 132 East Main Street 19709 or itams 23a U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: 1942-46 þ Specify: White 3 Widowed 4 Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State of Maryland permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any injury or other traumatic avant Elementary/Secondary (0-12) College (1-4or 5+) Environmental Agency Supervisor Twelve Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifford Gilbert ٥ Ella Bourne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lydia A. Gilbert (wife) 132 East Main Street, Middletown, Delaware 19709 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State R.A. Ferris & Co.,Inc. 11/12/04 West Chester, Pennsylvania \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signafure of Funeral Service Lieensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician DEVENE 2HETMEN2S /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown (AD Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? certificate 1 🗆 Yes 20 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Jo. 1 Inpatient 2 ER/Outpatient 3 DOA this funeral Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Diractor: After To the Hospital or Attending 1 XNatural 5 Pending investigation death. 1 ☐ Yes 2 ☑ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by after 4 Homicide within 24 hours a To tha Funaral C 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medisal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29c. License number 29b. Signature and title of ehttier 29d. Date signed (Month, Day, Year) 1)5467 11 MOV 04 30. Name and addr who completed cause of death (Item 23a) (Type, Print) 3+1VA 72 CHURCHMANS MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of M	Maryland / De	epartmer Certificat			nd Mental H		004	37799
	Physicia		1. Decedent's Name (First, Middle, Las	st)					2. Date of D		Year	3. Time of Death
	/Medic	al		aller		45 635	Taura and			oer®,	2004 unty of Death	6:15 A. M
	Examin	er	4a. Facility Name (If not institution, given 85 Norman Aven		r)		Town, or Lo		Death	4c. Co	Harfo	
	Funeral		5. Social Security Number 6. S	ex 7. A	Age (In yrs. last birth			f Under 24 Hours	Hrs. 8. Date of B	irth	9. Birth	place (State or Foreign
	Director		216-14-4617	□ M 2 🖾 F	81 Y	s. Months	Days	nouis	Min. 11/18	722	Mar	yland
	and bw tt		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d, Inside City Limits
	Mary -1 sh	tor	MD Harford		Aberde	en						1XXYes 2 ☐ No
	th the or 28c	Director	10e. Street and Number			10f. Zip				-	of What Cou	untry?
	ath wi	rai	85 Norman Aven				21001		0/0 // 1/		S.A.	to the desired
	ilied within 72 hours after death with the Maryland Hygiene. yther then "neturel", or Items 23a or 28e-f show yth, The Medical Examination multipe rollified at	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Forces 1 ☐ Yes 2 2	s?	13. Was Dece If Yes, spe	dent of Hisp cify Cuban,	Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)		Race - Amer Black, White	, etc.
036	ours af	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates		1 ☐ Yes	2 <b>X</b> No	Specify:		Sp	ecify:Whi	te
21215-0036	72 hc	Completed	15. Decedent's Ed (Specify only highest gra		16a. [	Decedent's Usu Give kind of wo life. DO NOT u	al Occupations dur	on ring most o	f working	16b. Kind	of Business/li	ndustry
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Maryland	should be and Mental s marked o umatic eve	To B	Bernard Dailey					Carr	ie Thomas			
Jan	2 sho		19a. Informant's Name/Relationship (						or Rural Route Num			ip Code)
	1 and Healtl tem 2;		Patricia A. Jos	sepn (s	sister) 20b. Place of D	Disposition (Na	me of	) L., J	Cowercity Date	1	7980 ion - City or T	own, State
ē	Pages ent of nt: If it ry or c		1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif		R. A.	crematory or c Perris		11	/10/04	West	Cheste	r, PA
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other treumatic en		21. Signature of Funeral Service Licer	1500 Bell	2 1	22. Name a Tarrii Aberd	nd Address ng-Car	of Facility 190 Fu Maryla	ineral Ho and 2100	ne, P. <sup>P.</sup> 1-3399	Α.	
,09/	Certificate be executed // Medical Examiner and physician and class as the burial-transit	icai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	as a consequence of	):	andi	al	Injar	ct		Interval Between Onset and Death  few Minute to herrs
.O. Box 68	death certific e attending p od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown		2 Fetal death at time of death	3 □Ectopic p 5 □ Other (s		, ·		23d	. Date of delive Month	very Day Year
S, P	res that the de igned by the a be detached t	by PI	Part II. Other significant conditions of	contributing to death	but not resulting in	the underlying	ause given	in Part I.	23e. Dio	tobacco use		the cause of death?
ord	v require been sig should b			Coro	nong	481 e	y.	1275	ease- 1	Yes 2 N	lo 3 Pro	bably 4 Munknown
Record	The lar ate has page 2	Completed		My Chr	muxica po	strue	true	Pulm	BISENSOBI	opsy	4b. Were aut prior to codeath?	opsy findings available ompletion of cause of 2 No
Vita	Attending Physician: Thir death.  •ctor: Atter this certificate by the funeral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 X No	Hospital:	atient 2 ER/Out	nationt 3 D	Other		f Death <i>Check only</i> ing Home 5×Re		Other (See	.6.1
o		$\vdash$	27. Manner of Death	28a. Date of Ir	njury 28b. Ti		28c. Injury a Work?	4 🗀 140131		how injury o		ny)
0	ending Fath. or: After he funer	atio	1 Natural 5 Pending investigatio	n	say reary	М		s 2 No				
Division of	i Pite	Certification:	3 Suicide 6 Could not be determined	28e. Place of	Injury - At home, fari etc. (Specify)	n, street, factor	y, office			(Street and Nown, State)	lum <i>ber or Rui</i>	ral Route Number,
	hours annered l		29a. Certifier 1 Certifying Ph	nysician: To the be	st of my knowledge,	death occurred	at the time,	, date and p	place, and due to th	e cause(s) an	d manner as	stated.
	To the Ho within 24 To the Fu	Medical	one)	and manner	of examination and stated.				occurred at the time			
ı	with To	Σ	29b. Signature and title of certifier	wra	7-B26		c. License r				igned (Month	-
	6		30. Name and address of person who	ion An	0 40	Type, Print)	de	6,5	ace,	nD,	2/	078
	Sta	ite	31. Date filed (Month, Day Year)	32. Regi	ar's Signature							
	Regist	rar	1404 - 3	7 2004	leve b	Long	K)					

			Please I	State of Ma	aryland / D	ера	artment of H	Health	and M					270	0.00
F	Physici	an	Registrar  1. Decedent's Name (First, Middle, Last) STEVE ALEXANDER		(	Sei	rtificate of	Death		2. Date of De Month NOVEMB				3 7 8	of Death
	/Medic Examir	cal	4a. Facility Name (If not institution, give FREDERICK MEMORI.	street and number)	AT.		4b. City, Town, o			MO A EMP	4c.	County of I	Death	3:19	Р м
	Funeral Director		Social Security Number		e (In yrs. last birth	day)	If Under 1 Year Months Days		Min.	8. Date of Bir (Month, Da April	rth ay, Year)	9.	Birthp	lace (State of	or Foreign V/Δ
	aryland show	٠.	Usual Residence of Decedent  10a. State  10b. County		10c. City, Town	or Lo	ocation			MPITI	1, 1.	740   50		0d. Inside C	City Limits
	vith the Ma or 28e-f	Director	Maryland Frederi  10e. Street and Number	ck	F	re	derick 10f. Zip Code				10g. Citi	zen of Wha	t Cour		: 2 <b>X</b> □ No
	ath w	ra	5601 Calvert Drive					1703				ed St	ate	2S	
136	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "naturel", or ltems 23e or 28e-f show event, I're Madeal Excriment must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2XN If Yes, Give Year or Dates:			Was Decedent of Hif Yes, specify Cub. 1 ☐ Yes ※☐ No	tispanic O an, Mexica Specify		cify Yes or No Rican, etc.)	)-	14. Race - / Black, \ Specify:		etc.	
1215-0036	thin 72 ho	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5		GIVA	dent's Usual Occup kind of work done DO NOT use retire	durina ma	st of workin	g	16b. Ki	nd of Busin	ess/Ind	lustry	
	filed within Hygiene. other than " ent, the Me	Co	12				Clerk					o Ind	lust	ry	
Maryland 2		To Be	17. Father's Name (First, Middle, Last)  James Habina			_		A	lma Fa						
<u>a</u>	12 sho h and 7 Is mu treum		19a. Informant's Name/Relationship (Ty Elizabeth Habina /	•			ng Address (Street Calvert				-			Code)	
	ges 1 and 2 should t of Health and Mer If item 27 is marke or other treumatic		20a. Method of Disposition	WITE		_				ate		cation - City		wn State	
Baltimore,	Pages nent of I int: If its iry or o		1 Burial 25 Cremation 3 R	emoval from State			sition (Name of matory or other place	-							
	permit. Page Department of Important; If any njury or once.		21. Signature of Funeral Service License		Freder		k Cremato  Name and Addre			2004 auffer				Mary1	and
ä	Dep fimp any		Tranker )	Stande	757		621 Oposs								21702
	48 m 8		3a. Parl. Enter the disea e, or complined hock, or heart failure. List only or	cations that acsed	the death. Do no							CK, I	iai y	Approximat	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	care	diac c	2 r	rhyte						/	Interval Bet Onset and	tween
	Examiner	er	Sequentially list conditions, lay, leading to inheritate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	too in	+0	stinal	6	(eec	ing				hou	15
,00,	te be executed ysician and e burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	dence of		olce	2						Unk	nown
200	certificate Iding phys	edic								-					
C. BOX	death e atter	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregnancy Other (specify)	′			2	3d. Date of Month		*	Year
7.	s this	by	Part II. Other significant conditions cor	tributing to death bu	it not resulting in t	he ur	nderlying cause giv	en in Part	ī.			se contribut		e cause of d	death?
ecords,	S D	Completed								24a. Was		24b. Wer	autop	sy findings	available
r	The ate h page		OF Was seen referred to modical							1 Yes	rmed? 2 No	deati	h?	npletion of c	ause or
VITAI	Physicien; this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	- a [] ED/O-1-		Oth			(Check only o					
_	5 9		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 Mnpatier 28a. Date of Injun (Month, Day		ne of	28c. Injun	4 🗆 N	28	e 5 Resid			Specify	1	
	- 9 -	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, farm . <i>(Specify)</i>	n, stre	eet, factory, office		28	Bf. Location (S City or Tov	Street and vn, State)	Number of	r Rural	Route Num	ber,
	To the Hospitel o within 24 hours at To the Funerel D completely filled in	edical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	sician: To the best of ner: On the basis of and manner stat	examination and/	death or inv	occurred at the tin restigation, in my o	ne, date ar pinion, dea	nd place, ar ath occurred	nd due to the	cause(s) date and	and manner place, and	r as sta due to	ited. the cause(s	:)
	To the within To the comp	M	29b. Signature and title of certifier  David U	). Kco	off, N	1	29c. Licens	e number	412			signed (M			
	X		30. Name and address of person who co				Print)								
			David W. Kos	32. Registra	310	L	U. Nint	4 St	reet,	Frede	rick	5 MD	) "	2170	) /
4	Sta Registr			2004 D	Lpara .	/	9 So	21/2							

State of Maryland / Department of Health and Mental Hygiene () () Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 18 **Physician** 2004 November 7:40 A M CLINTON K. HARDENBROOK /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Northampton Manor Nursing Home Frederick 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**∑**M 2□F 521-01-0956 Yrs. Director 91 May 5, 1913 Minnesota Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Colorado Larimer Loveland the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2895 North Empire Avenue #102 80538 or Iteme 23a U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than eny injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry G. Hardenbrook Clara Eva Sheeks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or, Town, State, Zip Code) Don Stonebrink/Grandson 25790 WCR 17 1/2, Milliken, Colorado, 80543 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Loveland Burial Park 11/30/2004 Loveland, Colorado 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DDC9 106 East Church Street Keeney and Basford P.A. Funeral Home Frederick, MD, 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition STAGE HEMMT FAILURE Physician END resulting in death) /Medical Due to (or as a consequence of) Examiner NEUMONIA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exam DIABETES Due to (or as a consequence of): Box 68760, attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? Month Dav Year 5 ☐ Other (specify) 4 Pregnant at time of death P.O. I ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 🗹 No 1 🗌 Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed?

1 Yes 2 No certificate or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3□ DOA this 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: the 6 ☐ Could not be determined 3 Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FOR DR ROWALD D0047951 ol UAJE miller) Mn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 814 TOLL HOUSE AUE. TREDETICK, MD 21701 A. KAZMI, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 3 0 2004

State of Maryland / Department of Health and Mental Hygienes 37802 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 12:10 p<sup>M</sup> M. Fredericka Hixon Nov. 16, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner FutureCare Chesapeake Anne Arundel Arnold If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep. 12, 1910 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7 Age (In vrs. last hirthday) **Funeral** 1□M 2XF Days Hours 94 Sep. Director 215-18-2481 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Iteme 23a or 28a-f ehow the Medical Examiner must be notified at Arnold 1 ☐ Yes 2 No MD Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21012 USA 302 Haskell Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritat Status 14. Race - American Indian. Black, White, etc. 1 and 2 should be tiled within 72 hours atter 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. δ 3 XWidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be tiled within Department of Heath and Mental Hygiene. Important: If Item 27 ie marked other than any injury or other traumetr. Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Susan Mertz Charles Vernon Stone 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fredericka Ann McKay/Daughter 302 Haskell Drive, Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nov. 18, 2004 1 Burial 2 XCremation 3 Removal from State Baltimore, MD 4 □ Donation 5 □ Other (Specify) Metro Crematory 21. Signature of Faneral Service Licenses 22. Name and Address of Facility Barranco & Sons, P. A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 an 23a. P. C. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** OSI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated asserts Examiner The law requires that the death certilicate be executed the burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a con Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 1 ☐ Yes 2 No 9 ☐ Unknown 5 Other (specify) be detached the 9□ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by all extremit 2X No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 Yes 1 ☐ Yes 2 ☐ No Physicien: 25. Was case referred to medical examiner? director, Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 7 2 ER/Outpatient 3□ DOA 5 Residence 6 Other (Specify) Alter this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: the Hospitel or Attending 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director:, completely tilled in by the t 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie #204 ghwain a 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 3 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 37803 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 78, 2004 Eleanor Ramona 1831 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Havre de Grace Harford Memorial Hospital 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | 5. Social Security Number 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F 87 Director 379-03-0493 Yrs Iowa Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or items 23e or 28e-f show The Medical Exprimer must be notified at MD Harford Aberdeen 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 U.S.A. 1708 Park Beach Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes ZXXIO If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home manager In home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be : 1 and 2 should be fii Health and Mental H tem 27 te marked ott Minnie Schinzel Roy Friedel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 nent of Health a ant: If item 27 to 1708 Park Beach Drive Aberdeen, MD 21001 (Husband) Earl R. Haaq 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. Harford Memorial Gdns.11/22/04 \* 4 □ Donation 5 □ Other (Specify) Aberdeen, MD 21. Signature of Funeral Service Licenses <sup>22</sup> Name and Address of Facility</sup> Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumania Praysician /Medical 65tuctive Lung Deseare Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, ed by the attending physician detached for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death bythot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2° Suldurel 1 🗌 Yes 2 No 3 Probably 4 □Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? res 2 X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Vital 25. Was case referred to medical examiner?
1 □ Yes 2 XNo 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ot this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Division 5 Pending death. investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo 2 ☐ Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) S. CLAUCON AUG. HARRE DE GRACE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. Galver 2 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 3 0 2004 Registrar

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			1 - For State Registrar	State of I	Maryland	d / Depa <i>Cer</i>	ırtmen <i>tificat</i> e	t of He	alth a eath	ınd M		giene Reg. No.	004	37804	
I	Physici		Decedent's Name (First, Middle, La  ROSS HARS	•							2. Date of De Month NOVEMB	Day	Year 2004	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, given	HMAN re street and number	er)		4b. City,	Town, or Lo	ocation of	f Death			ounty of Deat		_
	4.	3	Frederick Memo	rial Hosp	ital		Fred	deric	k			Fr	ederio	k	
19	Funeral Director			Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. Ia	ast birthday) Yrs.	If Under Months		f Under 2 Hours	Min.	8. Date of Bird (Month, Da Jan. 31,	th y, Year) 1921	1 Co	nplace (State or Foreign untry) y land	
	p ,		Usual Residence of Decedent		10- 01	Ŧ									
	anyla shov	'n	10a. State 10b. County			, Town or Lo								10d. Inside City Limits  ty□Yes 2□No	
	the N	Directo	Maryland Freder	LCK	Mye	rsvill	.e 10f. Zip	Codo				10a Citiza	n of What Co		_
	with Se or		110 Main Street					773				rog. Citize	USA	andy:	
	death ms 2;	Funeral	11. Marital Status	12. Was Decede		S. 13. V	Vas Deced	ent of Hisp	anic Orig	gin? (Spe	cify Yes or No Rican, etc.)	. 14.	. Race - Ame		_
9	after or Ita		1 ☐ Never Married 2X Married	Armed Force			_			, Puerto	Rican, etc.)		Black, White	-	
8	ural',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s:		☐ Yes 2	<b>A</b> 140	Specify:			St	pecify: W	nite	
<u>.</u>	be filed within 72 hours after death with the Maryland hall Hygiene.  Ad other than "natural", or items 23a or 28a-f show avent, it a Madical Exertical retains the rediffed at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	lent's Usua kind of wor	l Occupation for done dur e retired)	on ing most	of worki	n <i>g</i>	16b. Kind	of Business/I	ndustry	
2	withii lene. then	omp	Elementary/Secondary (0-12)	College (1-4d	or 5+)		k Dri					Tran	sporta	tion	
0	e filed I Hygid other ent, I	Be C	17. Father's Name (First, Middle, Las.	')				11	B. Mother	r's Name	(First, Middle.				
Maryland 21215-0036	2 should be to and Mental I is markad o raumatic ave	To B	Welty Caleb Ha	ırshman					Mar	y I	Ethel :	Hauve	r		
lar.	es 1 and 2 should b of Health and Ment f item 27 Is markad r othar traumatic a	0.2	19a. Informant's Name/Relationship	**							l Route Numbe			ip Code)	
	1 and Health em 27 thar tr		Hilda Harshman/v	nite	20h Pl	P.O. ace of Dispos			ersv		e, Mary		21773 tion - City or 1	Course State	
Ö	Pages nent of h int: If ite iry or of		1   Burial 2 □ Cremation 3 [		ce ce	imetery, cren	natory`or ol	her place)	<u> </u>				-	Maryland	
altimore,	permit. Page Department Important: I any injury o	1	* 4 ☐ Donation 5 ☐ Other (Special Signature of Fineral Service Lice		III.			d Address					Stree		-
a	permit. Departm Importar any inju		Vall Lit	eketh					,		me Mye			_	
			23a. Part1. Enter the disease or conshock, or hear failure. List only	plications that caus	sed the death									Approximate Interval Between	Ī
	Trysician	e 1	Immediate Cause (Final disease or condition	Ω	UCREA	Tic	CMF	BCIN	om.	4				Onset and Death	1
	/Medical Examiner		resulting in death)		as a consequ					,					
	LAdrimier	ē	Sequentially list conditions,	b. Due to (or	as a consequ	ence of):									4
16	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or migury that initiated events	D40 10 (01	as a consequ	erice or).									
, ,	execu n and ial-tra	Examin	that initiated events resulting in death) Last	C. Due to (or	as a consequ	ence of):									
3760,	cate be executed ohysician and the burial-transit	dical		_ d.											
9	ing ph e as t		IF FEMALE:									1.0.00			
Вох	death certific e attending p id for use as l	Physician/Me	23b. Was decedent pregnant in the past 12 months?		me of pregnar n 2 □ Fetal t at time of de	death 3 🗌	Ectopic pre					23d	<ol> <li>Date of deliverships</li> </ol>	very Day Year	
o l	0 0 0	ysic	1 Urknown	9☐ Unknow		aui 5	Other (spe	-cny)	-						
ر. ص	law requires that the as been signed by th 2 should be detache	by Pr	Part II. Other significant conditions	contributing to death	h but not resu	lting in the un	derlying ca	use given	in Part I.		23e. Did to	bacco use	contribute to	the cause of death?	1
g	w require been sig should b										1 □ Y	es 201	No 3□Pro	babiy 4 Unknown	
Records,	law re as be 2 sho	Completed									24a. Was		24b. Were aut	opsy findings available ompletion of cause of	
_	: The law cate has I page 2 s	Con									perfor		death? 1 🗌 Yes	2 No	
Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:							(Check only o				
	hys at di	- To	1 Tes 2 No  27. Manner of Death	Inpa		R/Outpatient 28b. Time of		A Bc. Injury at			ne 5 Resid			ify)	-
ou .	Attending ir death. actor: After by the funer	ition	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of li (Month, i	Day Year)	Injury	М	Work?	s 2 □ N			,,			1
Division of	or Attending Patter death. I Diractor: After to in by the funera	ertification;	3 Suicide 6 Could not be determined	286. Place of	Injury - At hor etc. (Specify)	me, farm, stre	et, factory	office		2	8f. Location (S City or Tow		lumber or Rui	al Route Number,	-
ā	spital or A ours after neral Dira filled in b	Cert	/ / /	ballaling,	etc. (Specify)	,						ri, State)			
;	To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in by	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the be miner: On the basis and manner	s of examinati	vledge, death on and/or inv	occurred a estigation,	at the time, in my opini	date and ion, death	i place, a h occurre	and due to the o	ause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)	
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier					License n				29d. Date s	igned (Month	Day, Year)	+
			100g	TH.D				00	47	95	(	11 -	21-1	2004	
	5		30 Name and address of person who		of death (Item		Print) H	DU! +	- A	UE"	fRED	ERICK	, MO	21701.	-
0	Sta	-	31. Date filed (Month, Day, Year)	32. Regi	strar's Signat				-						-
£	Registr	ar	NOV 3 0 2	UU4   100	eneva	Ø	140	als	1						

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 37805 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death NOVEMBER 8 2004 **Physician** 9:10 AM LOUISE INGRAM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Prince Georges

9. Birthplace (State or Foreign Country) Cresent City Nursing Home Riverdale If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthdey) **Funeral** 1□M 2⊠F Months Days Hours Min. Yrs. Director 84 March 17 1920 Georgia 167-24-3697 Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. 2ther than "natural", or flems 23a or 28a-f show ent, the Medical Examiner must be notitled at 1 ☑ Yes 2 ☐ No Funeral Directo Prince George's Riverdale 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4409 East West Highway 20737 U.S.A. . Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ☑ Widowed 4 □ Divorced Black Completed Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private HomeMaker 12th other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If Itam 27 Ie marked oth any Injury or other traumatic even Be Amos Gilbert Jessie Cheney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Withrown/Daughter 301 N. Beauregard St. Unit 502 Alexandria, VA 22312 Alma 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2. Dicremation 3 ☐ Removal from State 4 □ Donetion 5 □ Other (Specify) 11/14/04 Riverdale, Maryland Riverdale Crematory 21. Şignature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) NTENIOSCIENTRE CANDIOVASCULAN DISALSE Examiner Due to (or as a consequence of) Examiner or Attending Physician: The lew requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) physician and Division of Vital Records, P.O. Box 68760 by Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ate has been sign page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 - Yes 2/1/140 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1☐ Yes 2☐ No Medicai Certification: To After this efter death.

I Director: After this of in by the funeral d 28c. Injury at Work? 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours eft To the Funeral DI completaly filled in the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

Paul Devore M.D.

NOV 1 6 2004

31. Date filed (Month, Day, Year)

1100 Mercantile Lane Largo, Maryland 20774

			1 - For State Registrar	State of Ma	ıryland	d / Depa <i>Cer</i>	irtment of I tificate of	lealth and Death		Reg. No.	04	37806	)
1	Physici /Medio		1. Decedent's Name (First, Middle, La CARROLLTON	st) N. JONES	5				2. Date of De Month NOVEME	Day	ž <sub>0</sub> 0	3. Time of Death	
	Examin Funeral Director		4a. Facility Name (If not institution, given the ster River 5. Social Security Number 213-24-1446 Usual Residence of Decedent 10a. State 10b. County	Hospital	76	ter ast birthday) Yrs.	Chest If Under 1 Year Months Days		s. 8. Date of Bir	Ken	9. Birth Cou Ma	place (State or Fore ntry) ryland 10d. Inside City Lim	
	e-fet	ctor	MD Kent	:	Ch	ester	town					1 <b>X</b> Yes 2 □	No
	ith the	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen o	of What Cou	ntry?	
	ath w		807 High St.				2162			U.S.A			
036	n 72 hours after death with the Maryland "neturel", or Items 23a or 28e-f ehow safeal Examiner must be natified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent 8 Armed Forces? 1  Yes 2 XN If Yes, Give Year or Dates:		If	Vas Decedent of I Yes, specify Cub ☐ Yes 2 X No	Hispanic Origin? (; ean, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	Spec	ace - Ameri lack, White cify:		
1215-0036	- 2	Completed	15. Decedent's Et (Specify only highest grade) Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	+)	(Give I life. E	OO NOT use retire	during most of wo			& C	oupling	
22	be filed withir tal Hygiene. d other then event, Ire M	Co	12 17. Father's Name (First, Middle, Last,	)		Shop	Floor	Manage	<b>r</b> me (First, Middle,	Manuf		rer	
Maryland 2		To Be	Gere Nichols						Pletze		arriv		
ar Z	d 2 should be th and Mental 7 le marked traumetic ev	j <del>.</del>	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	g Address (Street	and Number or A	lural Route Numbe	er, City or Tow	m, State, Zij	Code) 2164	15
	7 16		William C. Jon	es Jr (:	son)	3039	4 Duck	Pudd1e	Rd. Ke	ennedy	vill	e, MD.	
ore	of He		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □	Removal from State	ce	metery, crem	sition (Name of natory or other pla		Date	20c. Location	-		
Ě	Pages tment of tent: If it jury or o		' 4 ☐ Donation 5 ☐ Other (Specif	y) ,	Ch			ery 11/				wn, MD.	
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Figure al Service Li-	M	0051	0 11	8 West	Cross	St. Gal	ena,	hen MD.		∍cŀ
	Physician and /Medical Examiner building the prijet is the prijet it and the prijet	edical Examiner	Shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a Due to (or a)	conseque	ence of):	al h	emorr	huge	ST	ike	Approximate Interval Bet Neen Onset and Peath	<b>У</b>
O. Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the pastN2 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of total live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal o	death 3 🗌	Ectopic pregnanc Other (specify)	у			Date of deliver	ery Day Year	
rds, P	w requires that the been signed by th should be detache	ρ	Part II. Other significant conditions of	contributing to death bu	t not resul	lting in the un	derlying cause gr	ven in Part I.	1			he cause of death? pably 4 □Unknow	٧n
al Kecord	The taw ate has b page 2 sl	Completed							24a. Was autor perio 1 🗆 Yes		were auto prior to co death? 1 \( \text{Yes}	psy findings availat mpletion of cause of 2 \square	ole f
VItal	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Ott	200	ath (Check only 6				
lon of	ding Phy h. After this funeral d	ation: To	1 Yes 2 No  27 Manper of beath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	v 2	R/Outpatient 28b. Time of Injury	28c. Inju	4 🔲 Nursing i	Home 5 ☐ Resident 28d. Describe b			ý) 	
DIVISION	F = -	Certification:	3 Suicide 6 Could not b determined		ry - At hon . (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Nun m, State)	nber or Rura	al Route Number,	
	P F F F	edical	29a. Certifying Ph (Check only one) Certifying Ph 2 Medical Exar	nysician: To the best of niner: On the basis of and manner sta	examination	riedge, death on and/or inv	occurred at the ti estigation, in my o	me, date and place opinion, death occ	e, and due to the ourred at the time,	cause(s) and r date and place	nanner as s e, and due to	tated. the cause(s)	
	To the Vithin 2 To the complete	×	29b. Signature and title of certifier	lin-			29c. Licens	number 8	G	29d. Date sign	led (Modifi,	Dey, Year)	
			30. Name and address of person who Wayne D. Benj					Hill R	d. Chas	terto	นาท . ท	MD. 2162	20
	Sta	te	31. Date filed (Month, Day, Year)	32. Regista			CHALCH	TITIT K	G. CHES	CELCO	MIT 1	10. 2102	.0
	Registr	1.00	31. Date filed (Month, Day, Year)	5 2004	300	A.	Anna St						

State of Maryland / Department of Health and Mental Hygien 004 37807 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Nathanael Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Cecil Macintosh Colona If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F 218-65-3024 Usual Residence of Decedent Director Yrs Balkimon -01-2004 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1 Yes 2 No Director MD Cecil Colora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21917 USA 129 Macintosh Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA NIA NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event RAY SOHNSON JOHNSON ANDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOHNSON Colona 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Surial 2 Cremation 3 Removal from State NOTTI WE HAY 11-11-2004 Colona \*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility R.T. Fourd Funeral Home, 111 S. Queen Street, Rising Sun, MD 21911 uch ona 23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease ir condition resulting in death) hyllnifed disorder of glycosylation to for as a consequence of: Physician /Medical Examiner Scorday to Science Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is it leads as the cause of the cau Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1□ Yes 2□No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) After this c funeral dire 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signat 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blalock 1008 600 N Wolfe Street COHN 31. Date filed (Month Pay Year) NOV 12 State Registrar

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State of Maryland / Department of Health and Mental Hygien [ ]	4 37808
Certificate of Death	

			1 - For State Registrar	State of Marylan		tificate of D			1. No.	3/000
	Di		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Cornell Jon	es				Novemb	er 5,200	4 9:45 AM
	Examin	er	4e. Fecility Name (If not institution, give :	TI	- 100	4b. City, Town, or L	ocation of Death		4c. County of Dee	th'
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.	last birthday)		O// S If Under 24 Hrs.	8. Date of Birth (Month., Day, Y	7700 9. Bir	thplace (State or Foreign
	Director		216-01-9116	M 2□F 8	8 Yrs.	Months Days	Hours Min.	SYST, 5	1916 Ma	ountry)  /
	iand ow		Usual Residence of Decedent  10a. State  10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits
	Mary B-f sh	tor	Warrland Anne 1	trundel A	nnan	olis				1. Yes 2 No
	or 28	Director	10e. Street and Number		7	10f. Zip Code	4	100	. Citizen of What Co	ountry?
	sath w	eral	207 Windell AV	LNUC 12. Was Decedent Ever in U.	6 42.14	2140	/	$U_{i}$	14. Race - Ame	esat America
(0	r Item	Funeral	11. Marital Status  1 Never Married 2 Married	Armed Forces? 1  Yes 2  No	If	Vas Decedent of Hisp Yes, specify Cuban,		Rican, etc.)	Black, White	
903	ours a	d by	3	If Yes, Give 1940 Year or Dates: 1945			Specify:		Specify: B	lack
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show ite Madical Examiner must be notified at	Completed by	15. Decedent's Edu (Specify only highest grade	completed)	16a. Deced	ent's Usual Occupati kind of work done du OONOT use retired)	ion ring most of work	ing 16	6b. Kind of Business	/Industry
212	filed withi Hygiene. other ther	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)	Mess	Hall A	Henda	nt I	ecteral(	XYUNMIN
	be filed that Hygie of other seent, I	Bec	17. Father's Name (First, Middle, Last)			1	8. Mother's Name	e (First, Middle, Ma	iden Sumame)	
Maryland	should be and Mental is marked o	2	19a. Informant's Name/Relationship (Ty	- Deine	40h \$4-115-	g Address (Street an	totha	y veel	<u>n</u>	7.0.1
Ma			An Times /	wishten	207/	Address (Sireer and	AV 2 M 1.0	A House Number, C	ity or Town, State,	10 31401
ore,	es 1 and of Health if Itsm 27 ir other tr		20a. Method of Disposition		lace of Dispos	ition (Neme of atory or other place)		Date 20	c. Location - City or	Town, State
Baltimore,	Pa ant ury		1 ☑ Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)	20	estq a	te Men	ional No	V. 14 20H	Annap	dis. MD
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lighner	0	) 22.	Name and Address	of Facility			
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death	n. Do not ente	r the mode of dying,	Such as cardiac	prespiratory arrest	Da Frest	Approximate
1	Physician		Immediate Cause (Final disease or condition	e cause on each line.		Preme				Interval Between Onset and Death
Ž.	/Medical Examiner		resulting in death)	Due to (or as a consequ		,				- 60
0	Examiner	<u>-</u>	Sequentially list conditions, if any, leading to immediate		ence of):					
	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
, 0,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a consequ	ience of):					
09289	ificate be executed g physician and as the burial-transit	edical		-						
Box 6			IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregna	ncy				23d. Date of del	livery
	death	Physiclan/N	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	that the dended by the a		9 ☐ Unknown  Part II. Dther significant conditions con		ulting in the up	dorhina cauca awaa	in Bart I	23a Did toha	200 USO contributo to	the cause of death?
Records,	90	d by	Tarri, Ballor significant conditions (of	tributing to death but not rest	inting in the arr	delihilid cadae diveri	in raiti.	1 ☐ Yes		obably 4 Unknown
000	law requir as been si 2 should	olete						24a. Was an	24b. Were au	utopsy findings available completion of cause of
I Re		Completed						autopsy performe 1 Yes 2	d? death?	completion of cause of
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			26. Place of Death	(Check only one)		
of	Phys this ral dii	i: To	1 Yes 2 No	1 L Inpatient 2 L	ER/Outpatient 28b. Time of	3 DOA Other:		me 5 Residence	be 6 Other (Specialized	cify)
ion	Attending F ir death. sctor: After by the funera	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer)	Injury	Work?	s 2 No		,,	
Division	of or Attend after death Director: / d in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
	e Hospital c 24 hours af a Funaral D etely filled in		29a. Certifier 1 → Certifying Phys	ician. To the best of multiple	ulada da da					
	To the Hospital or Attendi within 24 hours after death To tha Funaral Director: A completely filled in by the fu	edical	(Check only one)	ician: To the best of my knowner: On the basis of examinat and manner stated.	viedge, death ion and/or inve	occurred at the time, estigation, in my opin	, date and place, a nion, death occurr	and due to the caus ed at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and tifle of certifier			29c. License n			Date signed (Monti	
,			17 y y juni	W)		032	956		11/9/10	04
			30. Name and address of preson who co	mpleted cause of death (Item	23a) (Type, P	rint) and	Drive	Clask	~ Mi) :	1619
	Sta	-	31. Date filed (Month Cay Year)	32. gistrar's Signal		9				
	Registr	ar	104 - 9 C	THE PARTY IN		DOCK D				

			Ter State Registrar	State of M	arylan		artment of H			giene	27000
	Physici	an	Decedent's Name (First, Middle, Last)     Lillian Lou:	ise Kee	ler				2. Date of Dea	Th C U U 4	3. Firme of Death ar 12:10 Р м
	/Medic Examin	-	4a. Facility Name (If not institution, give st	reet and number)	)	ital	4b. City, Town, or Clintor	Location of Deat		4c. County of E	
	Funeral Director		5. Social Security Number 6. Sex 579 24 4325	7. Ag		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt (Month Day Oct 10	y, Year) 16 V:	Birthplace (State or Foreign Country) Lrginia
	Maryland B-f show	stor	Usual Residence of Decedent  10a. State  10b. County  Maryland Charles	County		y, Town or Lo	ecation				10d. Inside City Limits 1 ☐ Yes 2 ☑ Mo
	with the 3a or 28a	I Director	10e. Street and Number 2397 Windsor Par	k Court			10f. Zip Code	20602		10g. Citizen of What United St	-
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It a Modical Exactinal count be notified at once.	by Funeral	11. Marital Status 1 1 Never Married 2 Married 3 X Widowed 4 Divorced	2. Was Decedent Armed Forces 1 Tes 2 X If Yes, Give Year or Dates:	?		Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - A Black, V Specify:	American Indian, Vhite, etc. White
Maryland 21215-0036	within 72 hou iene. r than "natura Ite Medical E	Completed	15. Decedent's Educ (Specify only highest grade	ation completed) College (1-4or	5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wo	rking	16b. Kind of Busine Federal (	ess/industry Government
land 2	uld be filed Aental Hygi rked other tic event,	To Be C	17. Father's Name (First, Middle, Last)  James Elmer Bu	ck					me (First, Middle, Smith Pa	Maiden Sumame) BCE	
Mary	is 1 and 2 shoi of Health and M item 27 is ma other trauma		19a. Informant's Name/Relationship (Type James H. Keeler,				ng Address <i>(Street</i> Windsor			or, City or Town, State	te, <i>Zip Code)</i> 20602
Baltimore,	bages 1 a ant of Hea nt: If item y or othe		20a. Method of Disposition  1 XX Surial 2 □ Cremation 3 □ Re  1 4 □ Donation 5 □ Other (Specify)	moval from State	9		sition (Name of matory or other place [emorial (	i		20c. Location · City	
Baltii	permit. F Departm Importer any injur		21. Signature of Fun al Service Licepse	h 100	15_	22	2. Name and Addres	ss of Facility Le	e Funera		c 6633 01d
	Physician:		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that cause cause on each I	d the death line. 2515	h. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
8760,	Medical Examiner  bhysician and the prial-transit	dical Examiner	Sequentially list conditions, if any, returning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	EBRO	VAS C	UM	Acci	DENT		
.O. Box 6	ne death certifi the attending thed for use as	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 🗌 Feta	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
s, p	sign d be	by P	Part II. Other significant conditions con	ributing to death I		ulting in the u	nderlying cause giv	en in Part I.			e to the cause of death?  Probably 4 Miknown
Vital Record	The law ate has b page 2 s	Completed							24a. Was autop perfor 1 Yes	sy prior	e autopsy findings available to completion of cause of h? Yes 2540
of	Attending Physicien: 1 r death. ector: After this certifical by the funeral director, p	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  1 Natural 5 Pending 2 Accident investigation	ospital: 1 Ninpati 28a. Date of Inj (Month, Da	jury	ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	er: 4 🗍 Nursing H		ne)  dence 6 ①Other (5  now injury occurred	Specify)
Division	i Sir e	Certification;	3 Suicide 6 Could not be determined	28e. Place of In building, e	njury - At ho	ome, farm, sti (y)	reet, factory, office		28f. Location (5 City or Tow		r Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	edical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best er: On the basis of and manner s	of examina	owledge, deat ition and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occi	e, and due to the ourred at the time, o	cause(s) and manne date and place, and	r as stated. due to the cause(s)
)	To t To t	Σ	29b. Signature and title of control				29c. Licens	e number		29d. Date signed ( <i>M</i>	Ogth, Day, Year)
(	B2		30. Name and address of person who converted to S.	Anna	death (Item	n 23a) (Type,	Print)		9 # 30	7 Cura	on MD 2038
	Sta Registi		31. Date filed (Month, Day, Year) NOV 1 5 20	32. Regist	trar's Signa	7501 ature#	Jane J				

	Please  1 - For State Registrar		indelible link. Ensure All partment of Health and Martificate of Death	-	_
Physician	1. Decedent's Name (First, Middle, Market Adele F. Ku	•		2. Date of Death Month Day	3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution,		4b. City, Town, or Location of Death		12,2004 6:30p M
Examine	Union Hospit	· ·	Elkton		Cecil
Funeral		. Sex 7. Age (In yrs. last birthd	av) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birthplace (State or Foreign
Director	082-18-4278 Usual Residence of Decedent	1□ M 25xF 80 Yrs		pril 4,19	24 New York
w in	10a. State 10b. County	10c. City, Town o	r Location		10d. Inside City Limits
alth and Mental Hygiene. n 27 is marked other then "neturel; or Items 23e or 28e-f ehow ner treumetic event, the Mudical Experiment outsit by nutling at To Be Completed by Funeral Director	MD Ceci	1 154 Kir	kcaldy Drive, El		1 € Yes 2 No
or 2 Direction	10e. Street and Number		10f. Zip Code	10g. Citize	en of What Country?
s 23e	154 Kirkcaldy		21921	U.S	
ltem Ture	11. Marital Status  1 □ Never Married 2 □ Married	Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto</li> </ol>	Rican, etc.)	Race - American Indian,     Black, White, etc.
el', or	3 Widowed 4 □ Divorced	1 ☐ Yes 2√ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	s	Decify: White
eture ted	15. Decedent's		ecedent's Usual Occupation	16b. Kind	d of Business/Industry
en *r	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+)	ive kind of work done during most of work e. DO NOT use retired)	ing	
ygiene. ner then "neture it, the Washeal E t. Ompleted	12		hool Bus Driver		ool District
d oth	17. Father's Name (First, Middle, La	st)	18. Mother's Name	e (First, Middle, Maiden Si	umame)
Men varke vatic	Antonio Gran			na DeBlas:	7
T is II	19a. Informant's Name/Relationship		ailing Address (Street and Number or Rura		
Health em 2 ther 1	Rev. Michael  20a. Method of Disposition		54 Kirkcaldy Dri		n, MD 21921 ation - City or Town, State
nt of :: If it	1 ☐ Burial ②★☐ Cremation 3	Removal from State cemetery, of	rematory or other place) Nove	mber	
Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or Items 23e or 28e-f ehow any injury or other treumetic event. It e Madical Examination into the treumetic event. It e Madical Examination in the following and the completed by Funeral Director	'4 □ Donation 5 □ Other (Spe 21. Signature of Fluneral Service Lice		erris, Inc. 15,	2004 West	t Chester, PA
Depui	DALST 10		Andrew G. Gee Fr	neral HOme	9
	23a. Part1. Ent r / e disease, o co	emplications that caused the death. Do not one cause on each line.	259 Fast Main St	riespira Elikton	MD 24109xmate
hysician	Immediate Causs (Final	AWTE RE	NAL FAILURE	-	
/Medical	disease or condition resulting in death)	a FICO   C   C   C   C   C   C   C   C   C		,	3weeks
xaminer	Our and the line and divine	b			
je je	Sequentially list conditions, if any, leading to in-rediat cause. Enter Underlying Cause (Disease or injury	Dua to (or as a consequence of):			
sician and burial-transit	Cause (Disease or injury that initiated events resulting in death) Last	c			
burial burial	resulting in death) cast	Due to (or as a consequence of):			
physic the b	),	d			
signed by the attending physical be detached for use as the lab.	IF FEMALE:	23c. If yes, outcome of pregnancy			d. Data of delivery
for u	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	230	d. Date of delivery  Month Day Year
y the iched	1  Yes 2  No 9  Unknown	9☐Unknown	o a cital (specify)		
y Ph	Part II. Other significant conditions	s contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacco use	contribute to the cause of death?
n sign	MYOCARDIAL	INFARCTION		1 ☐ Yes 2 ☐	No 3 Probably 4 → Hiknown
aate has been signe page 2 should be d	ISCHEMIC	BOWEL		24a. Was an	24b. Were autopsy findings available
age age				autopsy performed?	prior to completion of cause of death?
is certificate has director, page 2 in Post Complete Comp	25. Was case referred to medical		26. Place of Death	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☑ No
his cer I direct	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpa	Othor	me 5 Residence 6	□Other (Specify)
fter the neral	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury	e of 28c. Injury at	28d. Describe how injury of	
or: A the fu	2 Accident investigat		M 1 ☐ Yes 2 ☐ No		
rs after death.  el Director: After t led in by the funera  Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		street, factory, office	28f. Location (Street and f City or Town, State)	Number or Rural Route Number,
urs al			1		
Within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medic	29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical Ex	Physician: To the best of my knowledge, do aminer: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, a rinvestigation, in my opinion, death occurr	and due to the cause(s) are ed at the time, date and pl	nd manner as stated. lace, and due to the cause(s)
vithin somple	29b. Signature and title of certifier	0	29c. License number	29d. Date s	signed (Month, Day, Year)
- 5 Pm ()	1 Mashup	M.D	D0051197	NOVE	MBER 12, 2004
	· KALALDING				,
		no completed cause of death (Item 23a) (Type	pe, Print)		0.0-1
6	30. Name and a of person what the state of t	to completed cause of death (Item 23a) (Type $\sim$ STREET $+37$	pe, Print) 20, WILMINGTO	N, DE	19801
	~ 7	ocompleted cause of death (Item 23a) (Type STREET # 37	po, Print) 20, WILMINGTO	W, DE	19801

State Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

E KING		Please 1	ype or Print in Blac					
		1 - For State Registrar	State of Maryland / I	Department of I Certificate of			2004	37811
Physic		Decedent's Name (First, Middle, Last)	PAUL ELWOOD K	ING		2. Date of Death Month NOVEMBE	R <sup>Day</sup> , 2004	3. Time of Death 4:48 P M
/Medi Exami		4a. Facility Name (If not institution, give : 1 E MAYER DR	street and number)	4b. City, Town, FINKSE	or Location of Death		4c. County of Death CARROLI	, CO
Funeral Director		5. Social Security Number 6. Set 215-54-7680	14 0DE	rthday) If Under 1 Year Yrs. Months Days	Hours Min.	B. Date of Birth (Month, Day, ) 4 / 26 / 1	Year) 9. Birthp Cour 946 MAR	place (State or Foreign ntry) YLAND
Maryland a-f show	tor	10a. State 10b. County MD . CARROLI	10c. City, Tow FIN	n or Location			1	0d. Inside City Limits 1 ☐ Yes 2X No
th with the 23s or 28	ai Director	10e. Street and Number  1 EAST MAYER DE		10f. Zip Code 210	48	100	g. Citizen of What Cour	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic avant, if a Medical Exertinat be recitized an any Injury or other traumatic avant, if a Medical Exertinat be recitized an any Dates.	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 💆 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☒ No	Hispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: WHI	etc.
within 72 ho iene. than "natur re Medice	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16a Completed) College (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire MECHANI	during most of working d)	H	EATING & ONDITIONI	AIR
tould be filed with Mantal Hygier Inserted other the hatic avant, Its	To Be Co	17. Father's Name (First, Middle, Last)	ORIN KIN		18. Mother's Name (i			.NG
and 2 sho lealth and I m 27 Is ma har traums		19a. Informant's Name/Relationship (Ty) WILLIAM KING	- BROTHER 21	820 CLARKS	SBURG RD.	, BOYD	S, MD. 20	841
iit. Pages 1 intment of P intant: If ita njury or ot i.		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ R  14 □ Donation 5 □ Other (Specify)  21. Sign fur 1 □ all Service License	emoval from State EVERGRE	t Disposition (Name of ry, crematory or other pla EEN MEM.GA	RDENS 11/	11/04	oc. Location - City or To FINKSBUR FUNERAL HO	G, MD.
Depa Impo any I		► (2)/\		254 E. M	AIN ST., W	/ESTMIN	ISTER, MD	
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, other failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	Hyportensive ather bue to (or as a consequence	noscleretic car				Approximate Interval Between Onset and Death
be executed ician and burial-transit	ai Examiner	it stry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence					
ne death certificate be executed the attending physician and shed for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 Ectopic pregnanc 5 Other (specify)	y		23d. Date of delive Month	ery Day Year
The law requires that the de tte hes been signed by the a page 2 should be detached f	b	Part II. Other significant conditions con	tributing to death but not resulting in	n the underlying cause given	en in Part I.		cco use contribute to th	
	Completed					24a. Was an autopsy performe 1 X Yes 2	prior to con death?	psy findings available npletion of cause of 2 No
iding Physician: Th th. : After this certificate funeral director, pag	To Be	27. Manner of Death  1 K Natural 5 Pending	28a. Date of Injury 28b. 1	njury Wo	y at 280		ce 6 COther (Specify injury occurred	SCENE
tal or Attanding s after death. al Diractor: After ed in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specity)			Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
To the Hospital of within 24 hours af To the Funeral D completely filled in	edicai	(Check only one)	ician: To the best of my knowledge ler: On the basis of examination an and manner stated.	d/or investigation, in my o	pinion, death occurred	at the time, date	and place, and due to	the cause(s)
WIL	M	29b. Signature and title of certifier			e number C M E		. Date signed (Month, I	
V-4		30. Name and address of person who con LING LL. M.T.		(Type, Print) 111 Po	enn Street,	Baltim	ore, Maryla	and 21201

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV 1 0 2004

32. Registrar's Signature

			For State Registrar	State of Maryland	-	artment of H tificate of L		_	giene Rog. NO N	11.	37912
	Dbin		1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	ath Day	Yeer	3. Time of Death
	Physic /Medi		Thomas Harris	on Kennedy				11	08	04	4. 24 M
	Examir	ner	4a. Facility Name (If not institution, giv	re street and number)		4b. City, Town, or	Location of Death	١,.	4c. County		1
			NORTH HRUNG			Glen	Birni	e	HUN	EI	TRundel
В	Funeral Director		219-16-4/54	Sex   17. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	July 18	), Year) 3, 1924	9. Birthpl Count	ace (State or Foreign try)  MD
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation				10	Od. Inside City Limits
	Maryi f sho	ō	MD Anne A	cl.	en Bui	mio					1 ☐ Yes 2X No
	the 28a	Director	10e. Street and Number	Turder Gre	en bu	10f. Zip Code			10g. Citizen of V	Vhat Count	try?
	h with	ai D	1204 Leonard Dr	ive		2	1060		USA	1	
	deat	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S	pecify Yes or No	14. Race	e - America k, White, e	
5-0036	agas 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If it item 27 is marked other than "natural", or items 23a or 28a-1 show or other treumatic event, the Medical Examinat must be notified at	b	Never Married 2 Married 3 Widowed 4 Divorced	t TYes 2 □ No If Yes, Give Year or Dates:	ŀ	☐ Yes <b>2</b> ☐ <b>(</b> No	Specify:	01110411, 0(0.)	Specify		
2-0	72 ho	Completed	15. Decedent's E (Specify only highest gro			lent's Usual Occupa		kina	16b. Kind of Bu	ısiness/Ind	lustry
2	within 7 ene. then "r	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired,	)	Airig			
2	ygier ygier ygier th	ပ်		1		Auditor			State o		ryland
ng	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, the Ms	Be	17. Father's Name (First, Middle, Last				18. Mother's Nan			10)	
78	nould be to define the following the followi	ဥ	Edward A. Kenned	<del></del>	10h M-10-	. Add /04		Harriso		0	2.11
Maryland	d 2 st th and 7 Is n treun		19a. Informant's Name/Relationship ( Edward A. Kenned			g Address (Street a					
	1 and Health lem 27		20a. Method of Disposition	20b. Plac	ce of Dispos	sition (Name of		Date	20c. Location -		
Baltimore,	permit. Pagas 1 and Department of Health Important: If item 27 any injury or other tr once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special	JRIGMOVALITOM STATE	-	natory or other place cemation		9/2004	Hampst		
alti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice			Name and Address					
m	Depa Impo any ir		I John K/	(u)		112 Washi					21157
8760,	Physician personned person	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence	ce of:	tine De	dous rec	l'Asit	c Areyk		3 hours
P-		LQ		Due to (or as a consequent	nce of):						
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Towson, Md.

	Funeral Director		5. Social Security Number 218–18–4042	6. Sex 1 M M 2	7. Ag	e (In yrs. last bi	Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 4/24/
	aryland show	_	Usual Residence of Decedent  10a. State 10b. County			10c. City, Tov	vn or Loc	ation				
	the Ma 28a-f s	rector	MD • Ha	rfor	d			10f. Zip		hite	е На	all
	s 23a or	Funeral Director	4531 Harfor	-		V			21	161		
020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show myn injury or other traumetic event, the Medical Evantiest Livist be not find at once.	þ	11. Marital Status  1 □ Never Married 2 Marri 3 □ Widowed 4 □ Divorced	ied 1 [	as Decedent med Forces? Yes 2 74 Yes, Give ear or Detes:			as Deced Yes, spec		spenic Ori n, Mexicar Specify:		ecify Yes or No- Rican, etc.)
1215-0	vithin 72 ho ne. han "natur e Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grede com	pleted) ollege (1-4or t		Decede (Give k life. De	ent's Usue ind of wor O NOT us	rk doné d se retired,	lu <i>ring m</i> os )	t of work	ing
and 2	t be filed on the Hygie ad other the event, in	Be	17. Father's Neme (First, Middle,	Lest)	· · · · ·	Kirkw	,,,,,,	C's		mer 18. Mothe		e (First, Middle, i
Maryl	nd 2 should be filed withir aith and Mental Hygiene. 27 Is marked other than ir traumatic event, tre Me	2	Nathaniel  19e. Informent's Name/Relations!  Norma D. Kir	hip (Type, Pr	int)	198	o. Mailing	Address	(Street a	and Numbe	er or Run	Mae el Route Numbel nery Ro
Baltimore, Maryland 21215-0020	Pages 1 end 2 Tent of Health a Int: If Item 27 Is Iry or other trai		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (Sp.	3 □Remova	,	20b. Place of comete	of Disposi ery, creme	ition <i>(Nan</i> eto <i>ry</i> or o	ne of ther place	э)	real	1 <sup>2</sup> 1 <sup>6</sup> /22
Balti	permit. Pag Depertment Important: I any injury o		21. Signature of Funeral Service I		Parti	Vail	22.	Name and	d Addres Ku	s of Facilit Lrtz	& S	Son Fur Maryl
Box 68760, ≤	v requires that the death certificate be executed by the been signed by the ettending physician and should be detached for use as the bunal-transit	by Physiclan/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest  Part II. Other elgnificant condition	a b c d		g Canc Due to (or as a Due to (or as a	conseque	ence of):	ause give	n in Pert I.		23b. Did to
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-	> = 0)	Complet	Coronary ar	tery	dise	ase	127					perform 1 □ Ye
Vita	cian: ertifica ector,	a	25. Was case referred to medical examiner?	Manaita	1.				16.		of Death	(Check only on
Division of Vital Re	To the Hospital or Attending Physician: The law within 24 hours efter death.  To the Funeral Director: After this certificate hes t completely filled in by the funeral director, page 2 s	ition: To	1 Yes 2 No  27. Manner of Deeth 1 Natural 5 Pending 2 Accident		. 1 ☐ Inpetie Dete of Injui (Month, Day	v 28b.	Itpetient Time of Injury	3□ DO. M	Bc Injury Work	4 🗆 140		me 5 Reside 28d. Describe ho
Divisi	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	3 Suicide 6 Could n 4 Homicide determi		. Place of Injubulding, etc	ury - At home, fa c. (Specify)	ırm, stree	et, factory,	office		2	28f. Location (St. City or Town
٠	the Hospit in 24 hour the Funera	edical (	29a. Certifier the Certifying (Check only one)	xaminer: Or	To the best on the basis of d manner sta	examination an	dor inve	occurred a stigation,	it the time in my opi	e, date end inion, deat	d place, a	and due to the ca ed at the time, da
	Mith To 1	2	29b. Signature and title of certifier  Marke	Chal	hom	/			License	number 0907	7	29
	10		30. Name and address of person warie Chat			eeth (Item 23a) 6569 N			68	St.	Sin	ite 60
	Sta Registr		31. Date filed (Month, Day, Year)	-	32. Registra	r's Signature	G		~~	, ,	200	0

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 20. NATHANIEL Nov. 2004 CALVIN KIRKWOOD JR. 11:38 PM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 4531 Harford Creamery Road White Hall Harford Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes 2 No Og. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Farming Maiden Surname) Wright r, City or Town, State, Zip Code) 21161 White Hall.Md. 20c. Location - City or Town, State Hampstead, Maryland neral Home, P.A. and Approximate Interval Between Onset and Death 6 months bacco use contribute to the cause of death? es 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? n autopsy ned? 2 X No 1 ☐ Yes 2 ☐ No nce 6 Other (Specify) w injury occurred reet and Number or Rurel Route Number, n, State) ause(s) and manner as stated. ate and place, and due to the cause(s) 9d. Date signed (Month, Dey, Year) 11/22/2004 21204

State of Maryland / Department of Health and Mental Hygie 2e 0 37814 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death World mber Day 4 Physician 11615A M Dorothy K. Lucas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Pay, 3/1/22 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 ☐X0F Months 82 Yrs 239-18-5870 Camden, N.J. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at Director 1 □XYes 2 □ No District Heights P.G. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1919 Tanow Place 20747 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black 2 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Waute once. Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ William Keesee Carrie Bruce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert D. Keesee/Nephew 8608 Hamlin St., Landover, Md. 20785 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Purial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets. Cem. 11/19/04 Cheltenham, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc. Snam anu 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Syndrome Sepsis Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): burialattending physician for use as the buria Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pancytopenia 1 ☐ Yes 2 ☐ HO 3 ☐ Probably 4 ☐ Unknown Be Completed Failure 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has 2 🗆 No Division of Vital 1 Yes 2 No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 1 I patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death Director: / 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funerai C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 039550 11-15-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. Hajjar, Jr. m.D. 4850 Forbes Blvd Lanham, Md 20706 31. Date filed (Month, Day, Year) State **NOV** 1 6 2004 Registrar

			1 - For Amend Item 28f per me C838 12-9	partment of Health and leath		2004 37815
1			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici		Charles Larry Leager		NOVEMBER	2, 2004 3:02P. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death
			UNIVERSITY HOSPITAL	BALTIMORE		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	/) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign Country)
	Director		222–38–6878	Mondo Buyo Houro Man	03/20749	Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits
	Aaryli Feho	ō	Maryland Queen Anne's Maryde			1 □Yes 2X No
	28a-	ect	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
	with 3a or	<u></u>	1620 Peters Corner Road	21620		USA
	72 hours after death with the Maryland naturel; or Items 23a or 28a-f ehow Iteal Exand not not be incliffed at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - American Indian,
9	or items	F	Armed Forces?  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes, Give A	If Yes, specify Cuban, Mexican, Puen	to Hican, etc.)	Black, White, etc.
93	ours rei', o	d by	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: White
5-	72 h	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of wo	rking 16	6b. Kind of Business/Industry
121	within ene. then *	ld m	Elementary/Secondary (0-12) College (1-4or 5+)	ck Driver		Transportation
7	tygie ther t	ပိ	11 TTU 17. Father's Name (First, Middle, Last)		me (First, Middle, Ma	
Maryland 21215-0036	d be intal line	Be c	George Howard Leager		a Thompson	
<u> </u>	should Me mark	은		ling Address (Street and Number or Ru	ural Route Number, 0	City or Town, State, Zip Code)
Na	ges 1 and 2 should be filed within 72 hours after death with the Marylar to Health and Mental Hyglens. If it item 27 is marked other then "naturel", or items 23a or 28a-f show or other traumatic event, Its Medical Examates install by indifficed at		/**** 6	Peters Corner Roa	ad, Maryde	el, Maryland 21649
5	s 1 a f Hea item othe		20a. Method of Disposition 20b. Place of Dis	position (Name of ematory or other place)	Date 20	c. Location - City or Town, State
m <sub>0</sub>	Page ent o nt: if ry or		1 □ Removal from State 1 □ Cremation 3 □ Removal from State 2 □ Church H	ill Cemetery   11/0	08/2004 Ch	nurch Hill, MD
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other then any injury or other traumatic event, Item 20068.			22. Name and Address of Facility	. 0 37	Funeral Home, P.A.
m	Depar Impo any ir		Jasen Fellans 3	ellows, Hellenbell 70 W. Cypress Str	n & Newnam eet. Milli	ngton. MD 21651
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.			
	Physician		Immediate Cause (Final disease or condition Wultivol	Discusson.	)	Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):	100000	· · · · · · · · · · · · · · · · · · ·	
	Examiner		Sequentially list conditions, b			
	p #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	and I-tran	каш	that initiated events resulting in death) Last C.  Due to (or as a consequence of):			
8760,	death certificate be executed e attending physician and ad for use as the burial-transit		255 15 (6) 25 2 351354251155 51).			
687	phys phys s the	dicai	d			
	leath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	atter for t	ciar	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
O.	that the de ed by the detached	ıysi	1 Yes 2 No 9 Unknown			
0		by Pi	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
ğ	w requires been sign should be	pa			1 🗆 Yes	2 No 3 ☐ Probably 4 ☐ Unknown
Records,	> 0 5	Completed			24a. Was an	24b. Were autopsy findings available
H	0 2 0	шо			autopsy performe 1X Yes 2	prior to completion of cause of death?  ☐ No
Vital	icien: Th certificate rector, pag	O	25. Was case referred to medical	26. Place of Dea	ath (Check only one)	200
<b>→</b>	Physicien: this certific ral director,	To B	examiner? 1 X Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 X EV/Outpati	ent 3 DOA Other: 4 Nursing H	lome 5 ☐ Residence	ce 6 Other (Specify)
D O			27. Manner of Death 1 □ Natural 5 □ Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year) Injury			injury occurred Deceased driving
Sio	Attending r death. sctor: After oy the fune	catl	2 Accident investigation 11-Z-04 1:30	V M 1□Yes 2XNo		e collided w/truck
Division of	or At fter d direct on by	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
	spitel or At ours after o nerel Direc filled in by		road		Saw Mil	Rd. Battanore, MD
	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 ☐ Certifying Physicien: To the best of my knowledge, de. (Check only one) 2 ☐ Medicel Examiner: On the basis of examination and/or and manger stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the causurred at the time, date	se(s) and member governed.  a and place, and due to the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Month, Day, Year)
	ک ← ≼ ⊢			0.014.5		
			30. Name and address of person who completed cause of death (Item 23a) (Typ	O.C.M.E.	NO/	VEMBER 3,2004
			S. D. HOGAN		Raltimov	e, Maryland 21201
	Sta	te	31. Date filed (Month, Day, Year) 32. Re Strar's Signature		раттшоц	e, markrana 51501
	Regist		NOV 0 5 2004	And o		

			For Stata Registrar	State of	of Maryland		artmen <i>tificat</i>					giene	'	(	378	16
			1. Decedent's Name (First, Mide	die, Last)							2. Date of De				3. Time of	Death
	Physic /Medi		Michael Lisha	ck							Month Novem	Da ber	11, 20	ar 104	3:06	D M
	Examir		4a. Facility Name (If not institution		ımber)		4b. City,	Town, or	Location of	of Death			. County of D		3.00	1
			Frederick Mem	orial Hosp	oital		Fred	leric	k			Fr	ederio	ck		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th	9. 1	Birthpla	ce (State o	r Foreign
	Director		197-40-4900	1 X M 2 □ F	54	Yrs.	MICHUIS	Days	Hours	Will I.	Apr 16	,195	50 Pe	Country 2nns	ylvar	nia
	and *		Usual Residence of Decedent  10a. State 10b. Count	v	10c City	, Town or Lo	cation									
	Aaryl f sho	5		•										100	d. Inside Ci 1 🗌 Yes	-
	the the 288-	ect	10e. Street and Number	derick		Frede	10f. Zip	Codo				10- 04	tizen of What			
	with 3a or	0	7952 Parkland	Place			101. Zip		L701				U.S.A.	Countr	y r	
	ter death items 23	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.S	S. 13. V	Vas Deced			gin? (Spe	cify Yes or No		14. Race - Ai	mericar	Indian	
21215-0036	72 hours after death with the Maryland "neturel", or Items 23a or 28a-f show idical Evarier must be redified at	by	1 ☐ Never Married 2反 Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 ☐ Yes	orces? 2∰No ve	l:	Yes, spec		Specify:	i, Puerto F	cify Yes or No Rican, etc.)		Black, W		c.	
5-0	72 hc	Completed	15. Decede	nt's Education est grade completed)		16a. Deced	ent's Usua	I Occupa	tion	t of workin		16b. K	ind of Busine	ss/Indu	stry	
2	within ene. then	nple	Elementary/Secondary (0-12)	College (	1-4or 5+)		kind of wor OO NOT us	e retired)	unn <b>y</b> mosi	t or workin	g					
7	D D 5	Cor			4	Sales							od Serv	√ic∈	e Comp	pany
pu	be file ital Hy id oth event	Be	17. Father's Name (First, Middle John			T . 1	,				(First, Middle,		,			
Maryland	d 2 should be th and Mental 7 is marked o treumatic eve	J.	19a. Informant's Name/Relation	Nicho]	las	Lish		/01		lian			Kiselio			
Ma	12 s h an 7 is		Valerie Gulyas		life	7952	Park	land	l P <b>l</b> ac	ce. F	Route Number	ck.	Marvla	n, zip C and	o <i>de)</i> 2 <b>17</b> ∩1	
ře,	1 a Hea	1	20a. Method of Disposition			ace of Dispos metery, crem	sition (Nam	ne of			ate		ocation - City			-
E	Pages nent of int: If it		1 🔀 Burial 2 □ Cremation `4 □ Donation 5 □ Other (		State St.	John	s Cer	nete	ry   N	lov 1	5,2004	Fre	derick	. M	arvla	nd
Baltimore,	permit. Page Depertment of Importent: If any njury or once.		21. Signature of Funeral Service	Licensee			Name and	d Address	of Facilit	v						
	22 = 29		* Khym	16 Been	M00706		Keene 6 Eas	st Cl	Basi	ord I	P.A. Fu Freder	mer. ick	al Hom Marv	e Tano	1 217	01
в			23a. Part1. Enter the disease, of shock, or heart failure. Lis	t only one cause on e	aused the death. each line.	Do not ente	r the mode	of dying	, such as	cardiac or	respiratory ar	rest,	,	A Ir	pproximate iterval Betv	veen
	Physician	ŝ i	Immediate Cause (Final disease or condition	a Mu	10 (ard	diel	1~	far	ch	0 17					nset and D	1
	/Medical Examiner		resulting in death)		(or as a conseque	,										
	P. BILL	<u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	V	eb ctc									1 4	7 2	07
-77	ted nsit	nin	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>₹</b>	- 1	-								1		
,	execun n and al-tra	Examine	that initiated events resulting in death) Last	c. Due to	( r s a conseque	ence of):	• ^			_			_	7	yea	. ~ 5
68760,	icate be executed physician and s the burial-transit	dical		d												
		a)			<b>—</b>											
Box	eath certifi attending I I for use as	N/u	IF FEMALE: 23b. Was decedent pregnant		come of pregnan		Estania era					2	23d. Date of d	elivery		
	e dea he att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of dea		Ectopic pre Other (spe					23	Month	Da	ay Y	ear
P.O.	res that the de signed by the a be detached f	Phy	9 Unknown													
	law requires that the death certif as been signed by the attending 2 should be detached for use a.	by	Part II. Other significant condit	ons contributing to d	eath but not result	ting in the un	derlying ca	use giver	n in Part I.				se contribute			
0	w require been sign	eted									1,28TY	es 2L	]No 3□1	-robab	ly 4 ∐Ui	nknown
Vital Records,	has t	Completed									24a. Was a autop	sy	24b. Were a	comp	findings a letion of ca	variable use of
a	ate pag										perfor	med? 2 No	death? 1 ☐ Ye	s 2[	□No	
Ş	sicie: certif	Be	25. Was case referred to medica examiner?	Hospital							Check only or			-		
o	Phys	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date		R/Outpatient 28b. Time of		c. Injury	4 Nur		e 5 🗆 Resid			ecify)		
lon	ading Phy th. : After this s funeral o	tlor	1 Aatural 5 Pendi 2 Accident invest		th, Day Year)	Injury	М	Work?	r` es 2⊟N		. Doscribo 11	OW III (OI)	Cocamba			
Division	after death after death Director: d in by the f	ifica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	of Injury - At hom	ne, farm, stre	-				f. Location (S			Rural R	oute Numb	er,
ā	s afte	Certification:	4 Homicide	buildi	ng, etc. (Specify)						City or Tow	n, State)	)			
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After his certifical completely filled in by the funeral director, to		(Check only 5 Medical	ng Physician: To the Exeminar: On the based many	best of my knowl	ledge, death	occurred a	t the time	, date and	d place, an	d due to the c	ause(s)	and manner a	as state	d.	
	the I	Medical	one) 29b. Signature and title of certifie	and mani	ner stated.											
	Ž Š Č		h					License	number	1 4			e signed (Mor			34
,			30 Name and address of across		- M. D							4 3 V	124	J 1	-, -3	- 1
			30. Name and address of person Michael Lerne				,	)r ±	#E F	redor	rick M	[22°17]	land of	1701	)_/.20^	1
	Sta	te	31. Date tiled (Month, Day, Year,	32. H	egistrar's Signatu	re	/				ICK, I	ary.	Lang Z	L/UZ	<u>-430.</u>	L.
	Registr	ar	NOV	1 5 2004	Sener	~ /	9	do	uks	/						

			State of S	of Maryland / Depa Cer	rtment of Healt tificate of Dea	th and Me ath	ental Hygie	200	4	37817
	Dhi-i-i		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Dav	Year	3. Time of Death
	Physicia /Medic		E. Melvenie Lee			]	November		004	12:20 a <sup>M</sup>
1	Examin	er	4a. Facility Name (If not institution, give street and nu		4b. City, Town, or Locat			4c. County of		
			Westminster Nursing and		Westminst			Ca	arrol	1
	Funeral Director		5. Social Security Number 6. Sex 1 M 2554	7. Age (In yrs. last birthday).	If Under 1 Year If Ur Months Days Hou		8. Date of Birth (Month, Day, Y Jan 09	ear) 1924	Counti	ace (State or Foreign Y) Labama
			Usual Residence of Decedent				Jan 05 .	1,72.2		
	rylan how		10a. State 10b. County	10c. City, Town or Lo	cation				10	d. Inside City Limits
	Be-f s	cto	MD Carroll	Westr	ninster					1 ☐ Yes 2 🙀 No
	or 28	Sire	10e. Street and Number		10f. Zip Code		10g	. Citizen of W	hat Counti	ry?
	ath w	-a	375 Robins Way		21158			USA		
	tems	Funeral Director	Armed Fo	edent Ever in U.S. 13, V proes?	Vas Decedent of Hispanio f Yes, specify Cuban, Me	c Origin? (Spec xican, Puerto R	cify Yes or No- tican, etc.)		- America , White, e	
36	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show f e M. Jic. Exertil et reset the ricitific Jut	by F	1 Never Married 2 Married 1 Yes If Yes, Gi 3 Widowed 4 Novorced Year or D	ŞÇNo ve	☐ Yes 2 No Spe	ecify:		Specify:	TaTlo	ite
21215-0036	hour	edk	15. Decedent's Education		lent's Usual Occupation		16	b. Kind of Bus		
15	in 72 n ne	Completed	(Specify only highest grade completed)	(Give	kind of work done during OO NOT use retired)	most of workin	g 10	b. Kind of bus	51110-55/11101	Jally
212	y with	E O	Elementary/Secondary (0-12) College (		ashier			Pentac	gon	
פ	othe vent,	Bec	17. Father's Name (First, Middle, Last)		18. N	other's Name	(First, Middle, Ma.	iden Surname	a)	
/lar	should be filed vind Mental Hygie a marked other umatic event, tr	10 6	William Lee			Stella	Johnson			
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other treumatic event, it a Marical Exercitivative for the notified at once.		<sup>19a.</sup> Informant's Name/Relationship <i>(Type, Print)</i> Sovola Phillips/daughter		g Address (Street and Nu Robins Way		Route Number, C inster, N			Code)
ore,	es 1 a of Heg fitem		20a. Method of Disposition 1 ☐ Burial 2 XX emation 3 ☐ Removal from	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place)	Da	ate 20	c. Location - C	City or Tow	n, State
Ē	Pages Iment of I tent: If it		`4 ☐ Donation 5 ☐ Other (Specify)	Carroll C	Cremation In			Hampste		MD
Bal	permit. Departr Importe any inje		21. Signature of Funeral Service Licensee		Name and Address of F Titts Funer 112 Washingt					21157
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	aused the death. Do not ente					í	Approximate nterval Between
	Pnysician :	- 9	Immediate Cause (Final disease or condition	lofume	- Dise	land			-	Onset and Death
	/Medical Examiner		resulting in death)  Due to	(or a consequence of):	1 0 1					
Н			Sequentially list conditions, if any leading to immediate b. Due to	(or as a consequence of):	L'ye					Soyn
	bed sit	nlne	rf any leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consequence or):	U				-1	
	al-trai	Examiner	that initiated events c.	(or as a consequence of):					-	
8760,	icate be executed physician and s the burial-transit	dlcal	d							
9	tifical ng phy as th	a)								
Вох	eath certific attending p for use as	an/N	230. Was decedent pregnant	tcome of pregnancy pirth 2 Petal death 3 D	Ectopic pregnancy				of delivery	•
O. E	ie death the atte	Physician/M	in the past 12 months?  1 ☐ Yes 2 ANO 9 ☐ Unknown  1 ☐ Unknown	nant at time of death 5 🗆	Other (specify)			Mont	tn L	ay Year
Ω_	that the de led by the a detached f	Phy	Part II. Other significant conditions contributing to c	eath but not resulting in the ur	nderiving cause given in P	art I.	23e. Did tobac	co use contrib	bute to the	cause of death?
Records,	es pe	d by					1 🗆 Yes	2 <b>X</b> 10 3	3 ☐ Probat	bly 4 [Unknown
000	aw requir s been si 2 should I	Completed					24a. Was an	24b. W	ere autops	sy findings available
	The law cate has page 2 s	mo					autopsy performed 1 Yes 20	d? de	flor to comp eath? ☐ Yes 2	pletion of cause of
Vital		0	25. Was case referred to medical		26. F	Place of Death	(Check only one)	Litto		
	nysic lis ce direc	To B	examiner? 1  Yes 2 No Hospital: 1	Inpatient 2 ER/Outpatient	Other: 4	Nursing Hom	e 5 Residenc	e 6 Other	r (Specify)	
0 U			27. Manner of Death 1 Natural 5 Pending (Mor.	of Injury 28b. Time of Injury	28c. Injury at Work?	28	3d. Describe how	injury occurre	d	
0	ttendil death. stor: A	atlo	2 Accident investigation		M 1 Tes	2□No				
Division of	afor Attendated after death	Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place build	of Injury - At home, farm, stre ing, etc. <i>(Specify)</i>	eet, factory, office	28	Bf. Location (Stree City or Town, S	et and Number State)	r or Rural I	Route Number,
	pitel ours a erel C		29a. Certifier 1 X Certifying Physician: To the	hort of my knowledge death	ongured at the first	o and sizes	ad due to the	-(a)		
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Medical	(Check only 2 Medical Examiner: On the b	<ul> <li>best of my knowledge, death asis of examination and/or inv ner stated.</li> </ul>	restigation, in my opinion,	e and place, ar death occurred	d at the time, date	and place, ar	ner as stat nd due to t	he cause(s)
	within To th compl	Me	29b. Signature and title of certifier	10-4	29c. License numb	ber	29d.	Date signed	(Month, Da	ay, Year)
•	IN		John W. O hith	ella	D25	443	1	1/8/	200	4
	5		30. Name and address of person who completed cau	se of death (Item 23a) (Type, I	Print)	2	1	101	,	
			John W. Yhiddle 31. Date filed (Month, Day, Year) 32. F	CFON 688	D 25 Foole K	oad,	West	m/7	ste	MD215
	Sta Registra	96	NOV 0 9 2004	Ha - Le	1	,				- 1

DOS

~			1 - For Amend Item 1	State of M &4b per m	aryland/Dep le 6838/12p Ce	1004 cas rtificate of	lealth and I Death		giene () (	+ 37818
			1. Decedent's Name (First, Middle, Last	)				2. Date of De		3. Time of Death
	Physici /Medic		Harold Austin	Lipscomb				Month November	Day er 9. 20	04 1000 a M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	Location of Death		4c. County	<del>~~~</del>
			Malcolm Grow Ho	spital		Fort	Meade Meade		Princ	e Georges .
	Funeral		Social Security Number     6. Se		ge (In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 12/1/		Birthplace (State or Foreign Country)
	Director		232-36-6664	M 2□F	66 Yrs.			12/1/	1937	West "VA
	pu k		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or L	ocation				10d. Inside City Limits
	eho eho	7								1√□Yes 2□No
	the Marylan 28a-f ehow	ect	MD P.G.  10e. Street and Number		Forestv	111E			10g. Citizen of W	
	with a	ā					-			- '
	s 23	eral	2806 Norman Dr	12. Was Decedent	Ever in U.S. 13	Was Decedent of H		necify Yes or No	U.S.A	American Indian.
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "neturel; or Items 23e or 28e-f ehow other traumatic event; the Medical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Xes 2 If Yes, Give Year or Dates:	No 1500	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	o Rican, etc.)	1	k, White, etc.
215-0036	ture!	od b				dent's Usual Occup	etion		16h Kind of Bu	sisses/Industry
75	"ne"	Completed	15. Decedent's Edi (Specify only highest grad	ie completed)	(Give	kind of work done  DO NOT use retired	during most of wor	rking	16b. Kind of Bu	siness/industry
212	within ene.	m C	Elementary/Secondary (0-12)	College (1-4or:	5+)	rvisor	-7		II.S. Pe	ost Office
	filed withi Hygiene. other then ent, the M		17. Father's Name (First, Middle, Last)		Jugo		18. Mother's Nar	ne (First, Middle,	Maiden Sumame	
Maryland	ould be Mental varked o	To Be	Maceo Lipscomb				Alma Va	alentin	ie	
ary	should land Menis marke	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mail	ng Address (Street	and Number or Ru	ıral Route Numbe	er, City or Town, S	State, Zip Code)
	1 and 2 Health a tem 27 is		Jeanette Lipsco	mb/wife	2806	Norman	Dr.Fore	estvill	e, MD. 2	0747
ē,	es 1 a of Hez fitem		20a. Method of Disposition		20b. Place of Disp			Date		City or Town, State
E	Page lent o nt: If ry or		1 ☑Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify)		MD. Vet	-		17/04	Chelte	nham,MD.
Baltimore,	permit. Pages 1 au Department of Hea Importent: If item eny injury or othe once.		21. Signature of Funeral Service Licens		2	2. Name and Addre	ss of Facility H	anho	nd Edwa	arde
Ö	Depar Impo eny ir		Janua Zo	Duran	12 3	910 Sil				
	- At		23a. Part . Enter the disease, or comp	lications that cause	d the death. Do not en	ter the mode of dyir	ig, such as cardiad			Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	1 6	Sclevotic	Lardiovas		1		Onset and Death
7	/Medical		resulting in death)		a consequence of):	2000000000	300000	11 - 2 - 60 5		
Ε.	Examiner		Samuellally let out the on	b						
	<u> </u>	ner	Securation is conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):					
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
90,	ate be executed thysician and the burial-transit		1830 tally Last	Due to (or as	a consequence of):					
8760,	certificate be executed Iding physician and Ise as the burial-transii	Physiclan/Medical		d		· · · · · · · · · · · · · · · · · · ·				
9	leath certifica attending ph I for use as th	Me	IF FEMALE:	020 16 1100 01100						
Вох	death co	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy	1		23d. Date Mon	e of delivery oth Day Year
0	9 9 0	ysic	1 Yes 2 No	4□Pregnant a 9□Unknown	it time of death 51	Other (specify)				
Θ.	that the de ed by the detached	Ph	Part II. Other significant conditions co	entributing to death t	but not resulting in the i	ınderivina cause aıv	en in Part I.	23e. Did to	obacco use contri	bute to the cause of death?
Records,	w requires that been signed should be del	ed by						1 🗆 \		3 ☐ Probably 4 ☐ Unknown
၁၁	aw as b	Completed						24a. Was autop		Vere autopsy findings available rior to completion of cause of
Ä	9 4 9	E O						perfó	rmed?   de	eath? ☑ Yes 2 ☐ No
Vital	iicien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only o	ne)	
<b>\</b>	is dil	10 6	1 X Yes 2 □ No	Hospital: 1 🗌 Inpati	ent 2 ER/Outpatie	nt 35 DOA Oth	er: 4 🗌 Nursing H	lome 5 Resid	dence 6 Othe	r (Specify)
n of			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time o	of 28c. Injur Wor	y at k?	28d. Describe h	now injury occurre	bed
.io		atle	2 Accident investigation			M 1 🗆	Yes 2 □ No			
Division	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of in	ijury - At home, farm, si tc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tox		r or Rural Route Number,
0	urs af									
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical			t of my knowledge, dea of examination and/or it tated.					
	To the vithin To the comp	Ž	29b. Signature and title of certifier	_		29c. Licens	e number	1	_	(Month, Day, Year)
			Carof Ha	llan.	nd -	0	CME		November	10, 2004
-			30. Name and address of person who o	ompleted cause of	death (Item 23a) (Type	Print)	C1		• 11	
			CAROL HALLAN	und		111 P	enn Stre	et, Balt	imore, M	laryland ,21201
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  NOV 3 0 2		rar's Signature	Loo	1			

State of Maryland / Department of Health and Mental Hygiene 37819 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Year Physician CHARLES MTLLER November 12,2004 1:45AM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City. Town, or Locetion of Death 4c. County of Deeth Examiner Fort Washington Medical Center Prince George's Ft. Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 □ F Yrs Director 346-30-1208
Usuel Residence of Decedent November 10,1942 Chicago, Ill permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Depertment of Health and Maniel Hygiena. Important: If Itam 27 is marked other than "natural", or items 23s or 28a-1 show any lajury or other treumatic event, the Macical Evarance must be notified at once. 10a. Stete 10b. County 10e. City, Town or Location 10d. Inside City Limits N☐ Yes 2 ☐ No Prince George's Director MD Accokeek 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 20607 15317 Livingston Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1957 to If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black Š 3 ☐ Widowed 4 ☐ Divorced ear or Dates: 1962 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Postal Service Clark U.S. Government 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 Adolphus Miller Gertrude Mitchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Quy Thi Ho Miller /Wife 15317 Livingston Road, Accokeek, MD 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11/19/04 Alexandria VA Signature of Funeral Service Licensee 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Ave., Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Visalen Miscare ATherisclerch -Examiner Due to (or as a consequence of) Examiner bunef-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, nia betes Physiclan/Medical Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. werel Director: Attar this certificata has been signed by the filled in by tha funeral director, page 2 should be datached 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☑ Unknown څ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes 2x No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funerel Director: Atta complataly filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 1745365 11-12-2006 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) pld , frankligton MD 20746 11701 livingston ad Sidanons

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 6 2004

2. Registrer's Signature...

			1 - For State Registrar	State	of Maryla	ind / Dep <i>Ce</i>	artmen <i>rtificat</i>				lental Hy	giene 0	04	378	320
			1. Decedent's Name (First, Midd	le, Last)							2. Date of De	eath		3. Time	of Death
	Physici /Medic		Senora A. Mil	Ler								er 9,	Year 2004	1:21	l a <sup>M</sup>
	Examin	er	4a. Facility Name (If not institutio	-					Location	of Death		4c. Cour	nty of Death	1	
			Washington Adv				Tako			04 Uso			gomery		
П	Funeral Director		5. Social Security Number 245-38-5425	6. Sex 1 ☐ M 2 🖾 F	7. Age (in yr	s. last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bil (Month, Da	av. Year)	Cor	place (State untry)	_
			Usual Residence of Decedent		70						March	28,192	o Sout	th Car	colina
	how how		10a. State 10b. County		10c. (	City, Town or L	ocation							10d. Inside	City Limits
	Se-fs	Director	DC		Wa	shingto	n							tX□ Ye	s 2 No
	Aith th	Dìre	10e. Street and Number				10f. Zip					10g. Citizen o	of What Cou	intry?	
	s 23e	ral	33 K. Street N					001				USA			
	Item Item	Funeral	11. Marital Status 1 □ Never Married 2 □ Mar	Armed F	cedent Ever in orces? 2 No		Was Deced If Yes, spec	lent of Hi lify Cuba	ispanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		ace - Ameri lack, White		
336	urs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes G	ive		1 ☐ Yes	2 <b>/</b> 2 No	Specify:			Spec	Blac	o le	
Ö	72 ho	Completed		it's Education	1	16a. Dece	dent's Usua	l Occupa	ation			16b. Kind of			-
2	ithin 7	nple	Elementary/Secondary (0-12)	st grade completed College	(1-4or 5+)	life.	kind of wor DO NOT us	e retired	iuring mos ()	t of work	ng				
Maryland 21215-0036	ygien ygien her th		12th	1		Hou	sekee	per				Ameri		nivers	ity
and	ould be filed within 72 hours after death with the Maryland Mental Hyglene. arked other than "natural", or Items 23e or 28e-f show afte event, the Medical Exatic recruit to rigitled at	Be	17. Father's Name (First, Middle,	Last)							e (First, Middle	, Maiden Sum	ame)		
Š	hould d Mei mark matic	안	Unknown  19a. Informant's Name/Relations	thin (Type Print)		10b Maili	na Addrona	(Stroot)	Ada V		Courte Alumb	or City or Tou	- Ctata 7	:- C- d-)	
Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The marked other than "naturel", or flems 23e or 28e-1 show any injury or other treumatic event, the Medical Endit had mail by rudified at Once.		Tarryl Robinso		andson							er City or Tow tsville		p Code)	
ē,	tem ?		20a. Method of Disposition		20b	. Place of Dispo				-247.527	Date	20c. Location		own, State	
altimore,	Pages ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (5		JIGIG	enwood				VOV.	19.2004	Washir	neton	DC	
<u>=</u>	mit. I partm sortei r inju		21. Signature of Funeral Service		101							Jenkins			lome
m	Depa Impo any ir	13	Sehr	1	sens.	Ju- 7	16 Ke	nned	ly St	NW V	Vashing	ton, Do	2001	l 1	
			23a. Part1. Enter the disease, o shock, or heart failure. List	complications that only one cause on	caused the de	ath. Do not en	er the mode	e of dyin	g, such as	cardiac c	or respiratory a	rrest,		Approxim Interval B	etween
	Physician		Immediate Cause (Final disease or condition	-a SE	0515									Onset and	d Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):		A 4 1	. 10	0					
		-	Sequentially list conditions,	b. ILF	SYLL!	41016	1 L	AIL	-Un	1					
	ited nsit	Examiner	Sequentially list conditions, in any, is aurig to infine underscause. Enter Underlying Cause (Disease or injury	( 0	N 6-6	SITI	VB.	216	·ΛΩ-	T-	Cai	LUM	2		
Ć.	exectin and ial-tra	Exa	that initiated events resulting in death) Last	C. Due to	(or as a conse	equence of):					-	10101		Y	
8760	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical		d. C	DROF	MAN	4	+ U	TB	NY	Di	SEAS	E.		
89	ng ph	Med	IF FEMALE:												
Box	leath certific attending p	lan/I	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of preg birth 2 □Fe	tal death 3	Ectopic pre						Date of deliver	ery Day	Year
0	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unk	nant at time of nown	death 5	Other (spe	ecify)				, and the second	TOTAL	Day	Teal
ď.	res that the de signed by the a I be detached I		Part II. Other significant conditi	ons contributing to	death but not re	esulting in the u	nderlying ca	ause give	n in Part I.		23e. Did t	obacco use co	ntribute to t	the cause of	death?
Records,	uires n sign lid be	Completed by	DIABETI	25 MB	LLIT	US 12	) H.	YP	8000	and Ci	10	Yes 2□No	3 ☐ Prot	bably 4 [	Onknown
ō S	w require been si should b	lete	3) METABOL	10 BNC	E PHAI	OPATH	VI	Mi	ALD.	IBC	2 24a. Was	an 24b	Were auto	opsy finding	s available
Re	Physicien: The lav r this certificate has rral director, page 2 :	omo	5 ACIDA	250	1	HIC INT	+ 1	TIAI	الحريدا ا	THE	autor perfo	ormed?	prior to co death?	empletion of	cause of
		BeC	25. Was case referr o medica		Cilia	7/11/2 1/15	HLZII	1 1/10			↑ 1 □ Yes Check onl	2 No	1 🗆 Yes	2LI NO	
<u>&gt;</u>	hysic nis ce I direc	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🖸	Inpatient 2	☐ ER/Outpatier	t 3□ DO	A Othe	r: 4□Nu	rsing Hor	ne 5 ☐ Resid	dence 6 🗆 O	ther (Specia	fy)	
0	ing Ph víter th uneral		27. Manner of Death 1 Natural 5 ☐ Pendir	28a. Date (Mo.	of Injury oth, Day Year)	28b. Time of Injury	21	Bc. Injury Work	at	2	28d. Describe I	how injury occu	rred		
<u> </u>	Attendia death. ctor: A y the fu	catl	2 Accident investi	gation not be			М		/es 2 □ l						
Division of	after death. Director: After I in by the funer	Certification:	4 Homicide determ	nined 28e. Plac build	e of Injury - At ling, etc. (Spec	home, farm, str cify)	eet, factory	, office		12	City or Tox	Street and Num wn, State)	iber or Rura	al Route Nu	mber,
	spital ours cours nerel filled		29a. Certifier 1 Certifying	ng Physician: To th	e best of my ki	nowledne deat	occurred a	at the tim	e date an	d place a	and due to the	cause(s) and n	nanner as s	rtated	
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medicel one)	Exeminer: On the	pasis of examination	nation and/or in	estigation,	in my op	inion, deat	th occurre	ed at the time,	date and place	, and due to	o the cause	(s)
	To th within To th	Me	29b. Signature and title of certifie	A A. MA	mar	m).	29c.	License	number	1		29d. Date sign			
Λ	0		MARCHANIA	od 11.1.6			D	24	59.	)		NOVEMI	_	, 200	24.
1	(2)		30. Name and address of person	who completed cal	se of death (It	em 23a) Typa	Print) 3	50	1-TO	LED	OTEL	2078	7.0		
	0		1.1011111111111			14 1507	( ) <del>)</del>	YA	TTS	VILL	MD	2078	52.		
	Sta Registr		NOV 1 5		Registrar's Sign	nature	10								

State of Maryland / Department of Health and Mental Hygiens 101 For

		1 - For Stata Registrar	State of Marylan		tificate of			eng 0 0 4	37821
Phys		1. Decedent's Name (First, Middle, La CHARLENE M.	st) AZZEI				2. Date of Death Month	1 / 1 / 2 / 20 0 4 ·	3. Time of Death 1:30 P M
/Me Exan	dical niner	4a. Facility Name (If not institution, given 20 Greenwood				r Location of Deat Pines		4c. County of Death	
Funera Directo		5. Social Security Number 6. S 216-30-4618  Usual Residence of Decedent	Sex 2 7. Age (In yrs. I. 70	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		year) 1934 Ohi	place (State or Foreign intry) O
17215-0036 within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f show in Medical Evalue activities at	Director	10a. State 10b. County  Md. Worcest		y.Town orLoc Berlin					10d. Inside City Limits 1 🖾 Yes 2 🗌 No
eath with th	Funeral Dire	10e. Street and Number  20 Greenwood Lan  11. Marital Status	E 12. Was Decedent Ever in U.	S 13 V		21811		USA  14. Race - Ameri	
UU36 nours after of	à	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	☐ Yes 2K No	Specify:	pecify Yes or No- o Rican, etc.)	Black, White, Specify: Whi	etc.
ING 21215-UU36  be filed within 72 hours after death with the Marylar ital Hygiene. Ind other than "naturel", or Items 23a or 28a-f show event, the Medical Everta and maturel as	Completed	15. Decedent's E (Specify only highest gr.  Elementary/Secondary (0-12)  12	ducation ade completed) College (1-4or 5+)		ent's Usual Occupi kind of work done o DO NOT use retired Homemake:		rking	6b. Kind of Business/Ir  Own home	dustry
	To Be C	17. Father's Name (First, Middle, Last	Edward Luzious			Mona	ne <i>(First, Middle, M</i> Curran		
_ c = n -		19a. Informant's Name/Relationship ( Paul J. Mazzei - 20a. Method of Disposition	- husband	20 G		Lane, Be	erlin, Md	City or Town, State, Zip. 21811  Oc. Location - City or To	
Baltimore, permit. Pages 1 a Department of Hea Importent: If item any injury or othe		1  Burial 2  □ Cremation 3  □ 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Fixther bace	(y) Gat	e of H	atory or other place eaven Cer Name and Addres	netery	16-04 S: eall Fune:	ilver Sprin	g, Md.
	ā	23a. Part1. Enter the disease, or comshock, or heart failure. List only	indications that caused the death	6.	512 N.W.	Crain Hy	wy, Bowie	, Md. 20715	Approximate
Pnysicia /Medica Examine	ıl 💮	shock, or heart failure. List only Immediate Cause (Finat disease or condition resulting in death)	one cause on each line.  a. Due to (or as a consequ	10 M	yelou	ill			Interval Between Onset and Death
te	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequ	uence of):	5 MUC 1	hve r	WMMC	of Disso	<u>se</u>
<b>58 / 50,</b> rificate be executed g physician and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as a consequent	uence of):					
death cer death cer a attendir d for use	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
ords, F.C requires that the een signed by th hould be detache	by	Part II. Other significant conditions of	contributing to death but not resu	alting in the un	derlying cause give	en in Part I.		acco use contribute to the	ne cause of death?
The lar ate has	Completed						24a. Was an autopsy perform 1 \square Yes 2	prior to co	psy findings available mpletion of cause of
Phys rthis ral dii	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manyer of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	<sup>er:</sup> 4□ Nursing H	ome 5 Residen 28d. Describe how	ce 6 ☐ Other (Specif	v)
i Ditte	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify,	)			City or Town,		
Hos Pur ely	edical	29a. Certifier  (Check only one)  1  Certifying Plants   2  Medical Example   1  Medical Exam	nysician: To the best of my knowniner: On the basis of examination and manner stated.	wledge, death ion and/or inve	occurred at the time estigation, in my op	ne, date and place pinion, death occu	, and due to the cau rred at the time, dat	ise(s) and manner as si e and place, and due to	ated. the cause(s)
To the within 2 To the complete	×	29b. Signature and title of centries	R		29c. License	6053		d. Date signed (Month,	
KO		Nadia Angovi 9	733 Healthwa	y Dui		n,MD a	11811		
S Regis	taté strar	31. Date filed (Month, Day, Year)	3 Registrar's Signat		B.				
DHMH 17 Rev 1	/2001			1					•

State of Maryland / Department of Health and Mental Hygiene 37822 For State Registra/NEND#31,500#32,11/12/04,BMW,McCo Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** NOV.8,2004 9:31 AM M VERMIL A. MCNEILL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHEVERLY, MD. PRINCE GEORGE PRINCE GEORGE HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign SOUTH'Y CAROLINA 5. Social Security Number **Funeral** 1 M 2 XF 92 578-03-0490 Yrs. 04-22-1912 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Item 27 is marked other than "natural", or Items 23s or 28s-f shot other traumatic event, the MacTost Examinar must be notified at 1 X Yes 2 □ No WASHINGTON Director D.C. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20019 USA 5229 BASS PL. SE Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ★No If Yes, Give ★ Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nen of Health and Mental Hygiene. ant: if Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS US GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JIM MITCHELL IDA GUART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AMENETTA HOLSEY - GRANDDAUGHTER 5229BASS PL. WASHINGTON DC, 20019 altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of the important: If its sny injury or of once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) MT. OLIVET CEM. 11-15-04 WASHINGTON, DC permit. 22. Name and Address of Facility ARLINGTON FUNERAL HOME 21. Signature of Funeral Service Licensee 3901 N. FAIRFAX DR. ARLINGTON, VA 22203 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ata 010 /Medical e to (or as a consequence of): **Examiner** 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or s a consequence of) Examine and I-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-1 Box 68760. Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) ed by the a O. 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performe 2□ No 1 ☐ Yes 2 🔀 No 1 TYes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 21 ER/Outpatient 1 ☐ Yes 2 No 3 DOA 2 1 Inpatient this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct
completely filled in by filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my en Medical ( 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 Villeson 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) Pierson mo 3001 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State NOV 13 <del>2004</del> Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 37823 State of Maryland / Department of Health and Mental Hygier [ ] [ ] [ For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician**  $P^{M}$ 12, Carl Michna Michel November 2004 21:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Chester River Hospital CEnter Chestertown Kent If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 1₩ 2□F 467-38-9167 Feb.3,1928 76 TXDirector Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ahow 1 ☐ Yes 2 ☑ No MD Kent Rock Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5795 Chesapeake Villa Road 21661 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Never Married 2 ☐ Married 1X Yes 2 □ No 1 □ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Set & Costume Designer Entertainment/Arts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virginia Sheridan Michel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5465 Newt Downey Rd., ROck Hall, MD 21661 Margaret Barber/Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Chesapeake Cremation | Nov.15,2004 Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A Kul Speer ROad, CHestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** oronous /Medical Due to (or as a consequence of): **Examiner** Sacuentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed as the burial-trar Due to (or as a consequence of): Box 68760. physician IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? jo 4 Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9☐ Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No s been si 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? certificate 2 2 No To the Hospitel or Attending Physician: After this certific funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA Certification: To 1 🗌 Yes **Inpatient** 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: J 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10051786 30. Name and address of person who completed cau-e of death (Item 23a) (Type, Print)

Registrar

State

RD BHGB

restertown MD 21120

1200

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31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Maryland	Depa / Depa	rtment of H tificate of I	lealth and Death		gienen	04	37824	
	Physici		1. Decedent's Name (First, Middle, Last)  DARLENE		MOORE			Month	2. Date of Death Month Day Year 1652 M			
	/Medic Examin		4a. Fecility Name (If not institution, give: University of Maryla	nd Medical Cent		4b. City, Town, or Baltin	iore	th		inty of Death		
	Funeral Director		5. Social Security Number 6. Sep 213-66-6834	7. Age (In yrs. last	Yrs.	Months Days	If Under 24 Hrs Hours Min		<sup>Y</sup> 195	6 Del	nplace (State or Foreign Intry) Laware	
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f show if it inem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic avant, the Madical Examination ust be multified at	ector	10a. State 10b. County	10c. City, T							10d. Inside City Limits 1X Yes 2 □ No	
			MD Cecil Cecilton  10e. Street and Number 10f. Zip Code					10g. Citizen of What Cou			intra?	
		Di	119 Douglas Lane			21913			U.S.		antry	
		era	11. Marital Status	12. Was Decedent Ever in U.S.	13. W	/as Decedent of H	ispanic Origin? (S	Specify Yes or No		Race - Amer	ican Indian,	
920	ours after d al', or iten Examinat	by Funerai Director	1 🗷 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1	) if	Yes, specify Cuba ☐ Yes 2  No	in, Mexican, Puèr Specify:	to Rican, etc.)		Black, White		
21215-0036	d within 72 ho piene. r than "natur ha wedical	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	(Give k	ent's Usual Occup- tind of work done of O NOT use retired	during most of wa	orking	16b. Kind o	of Business/I	ndustry	
212		mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Asse	mbly Li	ne wor	ker	Food	d Pro	cessor	
	be filed tal Hygie d other avant, II	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sur	name)		
<u> a</u>	Z should be filed within and Mental Hygiene. ia marked other than raumatic avant, Iha M	10 E	Earl E. Moore					E. Edy				
Maryland			19a. Informant's Name/Relationship (Ty			Address (Street					ip Code) 21921	
	of Health of Health litem 27 i		Arrie Moore	(mother)		Holling	sworth	Manor		3 E1	kton, MD.	
Baltimore,	permit. Pages 1 Department of H Importent: If its any injury or ot		20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ P	lamoval from State cemi	etery, crem	atory or other place				•		
Εij			'4 □ Donation 5 □ Other (Specify)  21. Sign II re 3 Fun al Service Licens							lton,		
Ba			1	M0051	$0 \mid 11$	8 West	Cross	St. Gal	ena,	phen MD.	L. Schaech 21635	
8760,	To the Hospital or Attanding Physician: The law requires that the death certificate be executed XI within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and up in place of the funeral director, page 2 should be detached for use as the burial-transit or progression.		23a Part Enter the disease, or comples inock, or heart failure. List only or immediate Cause (Final disease or copolition			r the mode of dyin atoma	g, such as cardia	c or respiratory a	rest,		Approximate Interval Between Onset and Death	
			resulting in déath)	Due to (or as a consequent Coaquilop	nce of):						Zweeks	
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687		edical			,	7						
Вох		Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown						23d. Date of d Month		very Day Year	
ls, P.O.				ntributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unknown				
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Division of Vital Records,		Compi						24a. Was autor perfo 1 Yes	rmed?	prior to c death?	opsy findings available ompletion of cause of	
		Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)  lospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
		tion; To	27. Manner of Death  1. Natural 5 Pending	28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?					5   Residence 6   Other (Specify)  Describe how injury occurred			
		Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tox		umber or Ru	ral Route Number,	
		Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To the Within To the compl	Me	29b. Signature and title of cartifier	Z M.O		29c. Licens			29d. Date sig		2004	
			30. Name and address of person who or MARK (GVCH	ompleted cause of death (Item 23	3a) (Type, f	Print) Bal	tiror	,MO	2/2	201		
	Sta Regist		31. Date filed (Month, Day, Year)	ompleted cause of death (Item 2: 22 S. S. S. S. S. S. S. S. S. S. S. S. S.	* M	boots						

		1 - For State Registrar	•	/ Department of Health and Certificate of Death	Reg. N	1004 37875
Dhari		1. Decedent's Name (First, Middle, La	ast)		2. Date of Death Month Da	3. Time of Death
Physic /Med		Albert Mutterp			November 1	l2, 2004  5:00 A M
Exam	iner	4a. Facility Name (If not institution, giv	•	4b. City, Town, or Location of Deat Waldorf	h 40	c. County of Death Charles
		Waldorf Health  5. Social Security Number 6.5				
Funera Directo			1 <b>X</b> □M 2□F 78	Yrs. Months Days Hours Min.	Sept. 12,	9. Birthplace (State or Foreign Country) 1926 New York
D		Usual Residence of Decedent 10a. State 10b. County	100 City T	Fown or Location		10d. Inside City Limits
faryla shov	Į.					1 ☐ Yes XX No
the h	rect	Maryland Charle  10e. Street and Number	es Wa	aldorf 10f. Zip Code	10g. C	itizen of What Country?
h with	Funeral Director	7 Pagnell Circle		20602		JSA
death	ner	11. Marital Status	12. Was Decedent Ever in U.S. Amed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
IN ELL IS-UUSO filed within 72 hours after death with the Maryland Hygiene. ther than "natural, or Itams 23e or 28e-f show ant, the Medical Experience must be notifized at	by Fu	1 Never Married 2 Married	Armed Forces?  1/2/Yes 2 \( \text{No}\)  If Yes, Give Year or Dates: 1944-4		, ,	Specify: White
hours hours fural;	ed b	3 ☐ Widowed 4 ☐ Divorced		16a Decedent's Usual Occupation	16b.1	Kind of Business/Industry
on 72 nin 72 nin 72 nin 72 nin 18 nin	Completed	(Specify only highest gri Elementary/Secondary (0-12)		(Give kind of work done during most of wo life. DO NOT use retired)	rking	,
A with	Com	12	4	Pharmacist		Drug Store
id be file ental Hy ked oth c evant	Be	17. Father's Name (First, Middle, Last			me (First, Middle, Maide	n Sumame)
ryla nould d Men narke	2	William Mutterpe		19b. Mailing Address (Street and Number or Ri	Meltzer	or Town State Zin Code)
INICAL nd 2 sl lith and 127 ts r traur		Beatrice Mutterp		7 Pagnell Circle, Wald		
os 1 ar		20a. Method of Disposition	20b. Plac	ce of Disposition (Name of netery, crematory or other place)	Date 20c. t	Location - City or Town, State
Page ment cannot cannot cannot if		1 🕅 Burial 2 □ Cremation 3 ☐ '4 □ Donation 5 □ Other (Speci		Sinai Cemetery Nov.	14, 2004 La	akewood, NJ
BAIKIMOTE, INATYIANG ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural, or Itams 23e or 28e-f show any injury or other traumatic event, the Marylan Examinat must be notified at		21. Signature of Funeral Service	M00053	Huntt füneraf lager af lager P. O. Box 156, Wal	dorf, MD 20	0604
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/Medica		resulting in death)				
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VISION OT VITAL HECONDS, P.O. BOX 08/00,  Attanding Physicien: The law requires that the death certificate be executed as recath.  rector: After this certificate has been signed by the attending physician and by the tuneral director, page 2 should be detached for use as the burial-transit by	Iffication: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequent b.  Due to (or as a consequent c.  Due to (or as a consequent c.)  Due to (or as a consequent c.)  Due to (or as a consequent c.)  Due to (or as a consequent c.)  Due to (or as a consequent c.)  Pregnant at time of deat consequent c.)  Description of the consequent c.  Due to (or as a consequent c.)  Pregnant at time of deat consequent c.  Description of the consequent c.  Description	ace of):  Sy eath 3 Dectopic pregnancy th 5 Other (specify)  Ing in the underlying cause given in Part I.  Solution of Dector	23e. Did tobacco  1  Yes :  24a. Was an autopsy performed? 1  Yes 2  N  ath (Check only one)  Home 5  Residence 28d. Describe how inj  28f. Location (Street a City or Town, Sta	23d. Date of delivery Month Day Year  use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  6 Other (Specify) ury occurred  and Number or Rural Route Number,  te)  s) and manner as stated.
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		State of Maryland / Dep State Registrer  State of Maryland / Dep	artment of Health and Martificate of Death	lental Hygier	0004 01020
Physici		Decedent's Name (First, Middle, Last)     RAYMOND FRANCIS MACABOY			Oay Year 11:20P M
/Medio	er	4a. Facility Name (If not institution, give street and number) CHARLOTTE HALL VETERANS HOME	4b. City, Town, or Location of Death CHARLOTTE HALL	4	4c. County of Death ST. MARY 'S
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday, 1 M 2 F 81 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea DEC. 11,1	9. Birthplace (State or Foreign Country) 922 WASHINGTON, DC
a or 28a-f show Lbs notified at	Director	10a. State         10b. County         10c. City, Town or L           MD         ST. MARY 'S         CHARLOTTE           10e. Street and Number         29449 CHARLOTTE HALL ROAD			10d. Inside City Limits 1 □ Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
Department of Health and Mental Hygiene. Important: or Itams 23a or 28a-f show Important: If itam 27 is marked othar than "natural", or Itams 23a or 28a-f show any Injury or othar traumatic evant, the Medical Examiner must be notified at once.	d by Funeral I	11. Marital Status  1 ★ Never Married  2 ★ Married  3 ★ Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1★ Yes 2 No II Yes, Give Year or Dates: W.W.II	Was Decedent of Hispanic Origin? (Spulf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE
Hygiene. othar than "nat ant, the Mode	e Completed	(Specify only highest grade completed) (Give life.	sdent's Usual Occupation a kind of work done during most of work DO NOT use retired)  RITY GUARD  18. Mother's Name	ing	Kind of Business/Industry  PT. OF THE NAVY  en Sumame)
and Mental Is markad or raumatic sv	ToB		ing Address (Street and Number or Rura	-	v or Town, State, Zip Code)
ent of Health nt: If itam 27 ry or othar t		20a. Method of Disposition  1 Burial 2XX cremation 3 Removal from State	O SILVER BIRCH LAND osition (Name of Imatory or other place)  NOVE  LD-ECHOLS CRE, 15,	Date 20c. MBER	Location - City or Town, State
Departm Importa any Inju once:		21. Signature of Funeral Service Licensee 2	2. Name and Address of FacilityBRII B0195 THREE NOTCH I	NSFIELD-EC RD. CHARLO	HOLS FUNL.HME.,P.A. TTE HALL, MD 20622  Approximate
ysician Medical kaminer	niner	shock, or heart failure. List only one cause on each line.	Colon Concer	. roopilatory arrost,	Interval Between Onset and Death 3 Mon HM
ng physician and as the burial-transit	Medicai Examin	that initiated events resulting in death) Last   Due to (or as a consequence of):  d.			
been signed by the attending p should be detached for use as	Physician/M		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
een signed l hould be det	by	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	1 □ Yes	
2 5	e Completed	25. Was case referred to medical	26 Place of Death	24a. Was an autopsy performed? 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
within 24 hours after death.  To tha Funaral Diractor: After this certificate ha completely filled in by the funeral director, page	Certification: To B	examiner?  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined.	ont 3 DOA Other: 4 Nursing Ho  of 28c. Injury at Work?  M 1 Yes 2 No	me 5 Residence 28d. Describe how in	6 (20ther (Specify) ASS+. Liv) yr jury occurred
hours after unaral Dirac ily filled in by		4 Homicide determined 288. Place of injury Actionity, saiding, etc. (Specify)  29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place,	City or Town, Sta	(s) and manner as stated.
within 24 To tha F complete	Medical	29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, 5851 - Deale Churchton Road)  31. Date filed (Month, Day, Year)  NOV 1 5 2004			
5:		30. Name and address of person who completed cause of death (Item 23a) (Type, 5851 - Deale Churchton Road)  31. Date filed (Month Pay Year)	Print) GYAN.C. S d. Dealo	ND. 20	757
Sta Registi	ar	NOV 1 5 2004			

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 37827 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** NOVEMBERL 7:15 2004 Edward Joseph McCloskey /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Rising Sun
If Under 1 Year If Under 24 Hrs. Calvert Manor Healthcare Center If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours XXM 2□F Director 68 Sept.12,1936 Pennsylvania 173 28 3739 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if ten 27 is marked other than "natural", or Itams 23s or 10s any injury or other traumatic access. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Director Maryland Ceci1 North East 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 106 Kirks Mill Road 21901 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1955— 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced White 1959 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Technical Representative Xerox 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William McCloskey Julia McDevitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Arlene McCloskey/Wife 106 Kirks Mill Road, North East, Maryland 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Mayerdale Crematory NOVeMBER 20, \* 4 □Donation 5 □ Other (Specify) Newark, Delaware 21. Signature of Jungaal Service Licens 22. Name and Address of Facility Crouch Funeral Home lotel 127 South Main Street, North East, Maryland 21901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition KBPINSTONY + ALLUNE **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner ENEBROURSEVED ACCIDENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence ol): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 Live birth 2 | Fetal death Month Day Year detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Yes 2 No 3 Probably 4 Unknown ILATED MEG OPMOIDED been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed? res 20 No has page 2 certificate 2 No 1 ☐ Yes completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 3 DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27 Manner of Death Certification: Injury 5 Pending 1X Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deatl To the Funaral Diractor: 6 ☐ Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide ö To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified H58419 NOVEMBER 16, 2004 +IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RISING SUN MD 2191 1831 HAMIDELSIT O. a mastro 5000 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier [ ] [ ] [ 37828 For State Registra 1-Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death NOVEMBER, 9 Year 2004 **Physician** 11:00PM /Medical John Milton Myers 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 2 F Director 78 Jan 22 1926 214**-20-**8828 MD Usual Residence of Decedent the Manyland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other treumatic event, if a Medical Eran krenmust be notified at 1 ☐ Yes 2√5√No MD Carroll Westminster Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ō Items 23e 2506 Neudecker Road 21157 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ➡ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: þ Specify: White 3 Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Δ Quality Control Tech Dynatherm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Milton Myers 2 Anna McGrath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is eny injury or other treu QDCs. 2506 Neudecker Rd Westminster, MD 21157 Mary Ann Myers/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/13/2004 ⁴ 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery Parkville, MD 21. Signature of Funeral Service Lice Pritts Funeral Home and Chapel, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21157 Westminster, MD Approximate Interval Between Onset and Death Immediate Cause (Final Priysician DAYS disease or condition resulting in death) ACUTE RENAL FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi Exam and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, pe PERIPHERAL VASCULAR DISEASE 1 🗌 Yes 3 Probably 4 Unknown No Completed peed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Tes 2[ or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 XN0 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 1 Inpatient 2 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending Natural investigation 1 ☐ Yes 2 ☐ No death. after death Accident completely filled in by the 6 Could not be determined 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerel L 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number JU-3 D37254 terns 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON, MARYLAND 21204
32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

NOV 1 2 2004

Elsen It Sparke

State of Maryland / Department of Health and Mental Hygiens, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCT. 31 Day 2004 Year **Physician** 21:00PM Mearite Coley /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Cheverly <u>Prince G</u>eorges General Hospital If Under 1 Year If Under 24 Hrs.
Wonths Days Hours Min. 8. Date of Birth (Month, Dey, Year) 3/8/25 9. Birthplece (State or Foreign Country)
S.C. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1**X** M 2 □ F 251-26-6634 78 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f ahow ust be notified at Forestville 1 Yes 2 No P.G. MD Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 6597 Pennsylvania Ave#202 20747 U.S.A. death Funerai 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner: e filed within 72 hours after d if Hygiene. other than "natural", or Item Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Baker h and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be King Mearite Lena Perkerson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6597 Pennsylvania Ave#202Forestville 19a. Informant's Name/Relationship (Type, Print) Coley Mearite Jr./son item 27 I 20b. Place of Disposition (Name of 20c. Location - City or Town, State 11/5/04 20a. Method of Disposition Resultiention cem. permit. Pages Department of Important: If it any injury or o ö DE Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Clinton, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges and Edwards 3910 Silver Hill KDSuitland, MD. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death TIVE 73 Immediate Cause (Final G **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit and Physician: The law requires that the death certificate be execu resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 2 NO 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 □ No 1XIYes 1 Ses 2 🗆 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Dite of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Matural 5 Pending after death.

Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Hospital 1 Decrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) 29d, Date signed (Month, Dev. Year) 29b. Signature and title of certif 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Priot) CANTILE LN. LARGO, 40, 20.774 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State State State	ate of Maryland /			f Health of Deat			ene g. <b>2</b> 0 0	4 3783	30
	Physici	an	Decedent's Name (First, Middle, Last)  Output  Decedent's Name (First, Middle, Last)  Output  Decedent's Name (First, Middle, Last)						2. Date of Death Month	Dav	3. Time of De	
	/Medic Examir	al	Robert Ray Nye  4a. Facility Name (If not institution, give street	and number)	46	b. City. Tow	n, or Location		November	3, 200		A M
	LXamii	CI	Chestertown Nursing &				ertown			Ken		
	Funeral Director		5. Social Security Number 6. Sex 226-14-9601 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last bi	NA.	f Under 1 Ye Ionths Da		er 24 Hrs. Min.	8. Date of Birth (Month, Day, May 30,	<sup>Year)</sup> 1919	9. Birthplace (State or Fo Country) VA	oreign
	a-f show	ctor	10a. State	10c. City, Tov Rock	vn or Location						10d. Inside City L	
	with the	i Dire	10e. Street and Number 5882 Cottage Ave.		1	10f. Zip Cod 21661			10	g. Citizen of W	hat Country?	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other then "natural", or items 23a or 28a-f show early injury or other treumetic event, the Medical Examinar must be notified at ODGe.	by Funeral Director	11. Marital Status 12. W All	as Decedent Ever in U.S. med Forces? □Yes 2 ☑ No Yes, Give aar or Dates:		s Decedent of Ses, specify C			cify Yes or No- Rican, etc.)	14. Race Black	- American Indian, K. White, etc. White	
Maryland 21215-0036	within 72 hi lene. r then "natu he Medical	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) Co	pleted)	Decedent (Give kind life. DO I cuck I	d of work do NOT use re	ne during me tired)	ost of worki	ng	6b. Kind of Bus Transpo	rtation	
/land ?	ould be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last) Stuart Nye						(First, Middle, M known <sup>11</sup>	aiden Sumame	a)	
, Man	and 2 sho saith and I n 27 is me		19a. Informant's Name/Relationship ( <i>Type, Pi</i> Tracy Mummert/Grandd	aughter 58	882 Cc	ottage	e Ave,		Hall, M			
Baltimore,	Pages 1 ment of He ent: If Iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	ai irom State	ry, cremato	ory or other	place)				City or Town, State	
Ball	permit. Depart Import eny inj		21. Signature of Funeral Service Licensee  23a. Part1. Enter the disease, or complication	Yh	Fel1	lows.	Helfe: Road	nbein	& Newna	m, P.A. . MD 21	620	
l	Physician		Immediate Cause (Final disease or condition	s that caused the death. Do se on each line.	not enter th	ne mode of o	dying, such a	is cardiac o	r respiratory arres	st,	Approximate Interval Betwee Onset and Deat	en ith
k	/Medical Examiner			Due to (or as a consequence	of):						P	
8760,	certificate be executed rding physician and use as the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence								
P.O. Box 687	the death certifical by the attending phy ached for use as th	Physician/Medical	in the past 12 months?	/es, outcome of pregnancy ]Live birth 2 ∏Fetal death ]Pregnant at time of death ]Unknown		opic pregna her <i>(specify)</i>				23d. Date Mont	of delivery th Day Year	r
ecords, F	w requires that been signed b should be deta	ρχ	Part II. Other significant conditions contribute O alphaemer's Dise								oute to the cause of death	
Vital Heco		Completed	Domonie ATE	er & Periph O ASHO WIL	Leal X 3 M	arte	enal	Disea	24a. Was an autopsy performs	24b. We pri de	ere autopsy findings avai ior to completion of cause eath? Yes 2 \( \) No	ilable e of
	Physicien: r this certific ral director.	To Be	25. Was case referred to medical examiner?  1 \[ \text{Yes} 2 \[ \text{No} \]  Hospita	tl: 1 ☐ Inpatient 2 ☐ ER/Ou	utpatient 3	3□ DOA			Check onlone  1e 5 Residen		(Specify)	
DIVISION OF	ending Ph sath. or: After th he funeral		2 Accident investigation		Time of Injury	28c. ir	njuryat Work? i ☐ Yes 2 [	2	8d. Describe how			
OIVE	To the Hospital or Attending Prwithin 24 hours after death.  To the Funerel Director: After to completely filled in by the funera	Certification;	4 Homicide	<ul> <li>Place of Injury - At home, fa building, etc. (Specify)</li> </ul>					City or Town,	State)	r or Rural Route Number,	
	the Hosp in 24 hou he Fune pletely file	ledicai	one) 2 Medical Examiner: 0	To the best of my knowledge in the basis of examination an and manner stated.	e, death occ nd/or investi	igation, in m	y opinion, de	ath occurre	d at the time, dat	e and place, an	id due to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier  ///////////////////////////////////	nD.			2/3/	_		d. Date signed (	(Month, Day, Year)	
			30. Name and address of person who complete	ed cause of death (Item 23a)	(Type, Print	t) And.	Chan	terton	m. M	20 211	620	
	Sta Registr		31. Date filed (Month Pay Year) 8 2004	32. degistrar's Signatury	A		<u></u>					

			1 - For State Registrar	State of M	laryland / [	Departm <i>Certific</i>			nd Me		giene Reg. No. (	004	37831
	Physici	an	1. Decedent's Name (First, Midd Tame 5	lle, Last)	ata		-			2. Date of Dea	ath Day	Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution			4h C	ity, Town, or	Location of		Vอับ	40 C	2004 ounty of Death	6:50A M
4	Examir	ier	Riderwood Vil	•		40. 0		r Spr			1	ntgomer	
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last bin	thday) If Ur	der 1 Year	If Under 2		8. Date of Birtl			place (State or Foreign ntry)
	Director		579-09-6675	1 <b>)</b> ∑M 2□F	96	Yrs. Morn	ns Days	Hours	Mill.	8. Date of Birtl (Month, Day May 26,	1908	Mich	igan
	and and		Usual Residence of Decedent  10a. State 10b. Count	у	10c. City, Town	n or Location							10d. Inside City Limits
	Marylan -f show	to	MD Anne	Arundel	Cr	ofton							1 XYes 2 □ No
	h the	irec	10e. Street and Number				Zip Code				10g. Citize	n of What Cou	ntry?
	23e c	Funeral Director	1529 Eton Wa	у			2111	4				USA	
	tems	nuei	11. Marital Status	12. Was Deceden Armed Forces	?	13. Was De If Yes,	specify Cuba	spanic Orig n, Mexican,	in? (Spec Puerto R	rfy Yes or No- ican, etc.)	14	. Race - Ameri Black, White,	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	If Yes. Give		1 ☐ Ye	s 2□XNo	Specify:			Si	<sub>pecify:</sub> Whi	t o
5-0036	within 72 hours after death with the Maryland ane. than 'natural', or Items 23e or 28e-f show ta Madical Extration transition and		15. Decede	nt's Education		Decedent's l	Isual Occupa	ation			16b. Kind	of Business/In	
215	thin 7.	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed)  College (1-4or	5+)	(Give kind of life. DO NO	work done of Tuse retired	during most )	of working	9			
2121	filed wi Hygien other th	Con		5+		Dip1	omat					. Govt.	
and	I be fill hall Hed off	Be	17. Father's Name (First, Middle	•						(First, Middle, Johnson		umame)	
Maryland	should nd Men marke umatic	To	Theodore Ops  19a. Informant's Name/Relation		19h	Mailing Add	ess (Street :					own, State, Zir	Code)
Ma	and 2 s salth an n 27 is wer trau		Margaret A. Op			9 Kath				over, D	_ ′	19901	0 0000)
Je,	- I & =		20a. Method of Disposition		20b. Place of	Disposition (	Name of or other plac	θ)	Da			tion - City or Te	own, State
<u><u>Ë</u></u>	Pages ment of I ant: If its ury or o		1 ☐ Burial 2 ☑ Cremation  4 ☐ Donation 5 ☐ Other (		9	-			11-1	5-2004	Alex	andria,	VA.
<b>Baltimore</b> ,	permit. Departn Imports any inju		21. Signature of Funeral Service	Licensee	1 0		and Addres			11 Fune			
	70 = 6 Q		23a. Part1. Enter the disease, of	an Total	Ol the death. De s		NW Cra			Bowie,		20715	Approximate
	==-	8 II)	shock, or heart failure. Lis	it only one cause on each	line.	N STEEL THE T	node or dying	y, such as c	CI	respiratory arr	est,		Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	aDue to (or a	31+1CC		LOS:	hc	Ste	mosi	S		months
	Examiner		Conventially list conditions		maer	fure	h	eart	- 4	larly	re		
-	p #	iner	Sequentially list conditions, frank, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	a consequence o	of):	0.	1	(	)	10		
	secute and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of	-10	Car	duo.	me	popa	thy		2 month
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	cal E		33,0,0		,-			(	'	O		
9	tificate ig phys as the	ledic											
Вох	eath certif attending for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Petal death	3∏Ectopi	c pregnancy				230	d. Date of delive	,
O. E	at the death by the atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		at time of death	5 Other						Month	Day Year
٥.	that that detacl		Part II. Other significant condit	ions contributing to death	but not resulting in	the underlyin	in cause dive	n in Part I		23a. Did to	bacco use	contribute to t	he cause of death?
Records,	uires thai	d by		,	<b>-</b>		,				es 2 🗔		pably 4 Unknown
00	w requir s been s should	lete								24a. Was a	ın 2	24b. Were auto	psy findings available
	0 4 0	Completed	-							autops perfor	sy	prior to co death?	mpletion of cause of
Vital		Be C	25. Was case referred to medic examiner?	al				26. Place	of Death (	Check only or			202110
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 ❤️No		ient 2 ☐ ER/Out		DOA Othe	4 UNUI	-			Other (Specif	y)
		lon:	27. Manner of Death  1 ☑Natural 5 ☐ Pend		ury 28b. T ay Year) Ir	ime of njury M	28c. Injury Work	rat ⊲? ∕es 2⊟N		ld. Describe h	ow injury o	occurred	
Division	deat deat ctor: / the	fical	3 ☐ Suicide 6 ☐ Could	I not be 28e. Place of I	njury - At home, far		1	163 2 1		f. Location (S	treet and N	Number or Rura	al Route Number,
<u>S</u>	Dir	Certification;	4  Homicide determination	building, 6	etc."(Specify)					City or Town	n, State)		
	o the Hospital ithin 24 hours a o the Funeral I ompletely filled	Medical (	29a. Certifier 1 Certify (Check only 2 Medica one)	ng Physician: To the bes I Examiner: On the basis and manner s	of examination and	, death occur d/or investigat	ed at the tim ion, in my op	e, date and pinion, death	place, an	d due to the c d at the time, d	ause(s) an late and pl	nd manner as s ace, and due to	tated. o the cause(s)
	To the	Σ	29b. Signature and title of certifi	O $M$			29c. License			2	. 1	signed (Month,	
	(1)		Loveen		ing, t		ソラ	952	4		Nov	15,	2004
R			30. Name and address of person	who completed cause of	death (Item 23a) (	Type, Print) RACEF	IELD	ROA	D, S	LLVER	SPR11	16,MI	20904
	Sta Registr		31. Date filed (Month, Day, Year NOV 1 6 2	r) 🔎 🕰 Regis	trar's Signature				,				

DHMH 17 Rev 1/2001

			For State Ragistrar	Sta	te of Mary		artment of H		d Mental Hyg	giene Reg. No. 0 4	37832
			1. Decedent's Name (First, Midd.	le, Last)	-/-				2. Date of Dea	ath	3. Time of Death
	Physici /Medio		Barbara	S.	OB	rien			Nov	Day Year	5:58AM
	Examir		4a. Facility Name (If not institutio	n, give street a			4b. City, Town, or	r Location of De		4c. County of De	
			Renaissance Gar	den at	Riderwood	l Village	Silve	r Sprin	α	Montgom	erv
	Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Birt	h 9. B	irthplace (State or Foreign
	Director		039-07-0116	1 ☐ M 2	<b>⊠</b> F	81 Yrs.	Months Days	Hours M	in. (Month, Day Aug. 2		ode Island
	p .		Usual Residence of Decedent								
	show	_	10a. State 10b. County		10	c. City, Town or Lo	cation				10d. Inside City Limits
	Ba-f.s	cto	Maryland Mont	gomery		Silver	Spring				1 ☐ Yes 2 ☐ No
	iff th	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What (	Country?
	23a		3114 Gracefie	eld Roa	d, Apt.	415	20904	4		USA	
	r deg	Funeral	11. Marital Status	12. Wa	is Decedent Ever	r in U.S. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - An Black, Wh	nerican Indian,
98	d within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23a or 28a-f show Itra Medical Evandra frings be publised at		1 ☐ Never Married 2 XMar	If Y	]Yes 2X No 'es, Give		1 ☐ Yes 2 ☑ No	Specify:	, ,	Specify: Wh	
Ö	ural',	d by	3 Widowed 4 Divorced	Ye	ar or Dates:					Opecny. Wil	
<u>7</u>	72 na	Completed	15. Deceder (Specify only highe	it's Education st grade comp	oleted)	(Give	dent's Usual Occupa	during most of v	vorking	16b. Kind of Busines	s/Industry
12	within ene. than "	m m	Elementary/Secondary (0-12)	Co	llege (1-4or 5+)		DO NOT use retired	1)			
2	e filed within Il Hygiene. other than vant, the Me		17. Father's Name (First, Middle,	( aat)	4	Ноп	emaker	40. 14-45-4- 1	Inna (Class & Colors	Own Hom	e
Maryland 21215-0036		Be							lame (First, Middle,	Malden Sumame)	
3	2 should be a nand Mental I la marked o raumatic ava	<sup>2</sup>	Archibald She						Dwyer		
<u>a</u>	12 st		19a. Informant's Name/Relations		•					r, City or Town, State,	20304
6	l and lealth im 27 har t		James O'Brien,	Husban				eld Road			Spring, MD
0	Gordina Control		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Remova		20b. Place of Dispo cemetery, crer	natory or other plac f Heaven	(e) Nov	Pember 13	20c. Location - City of	r Town, State
Ë	tmen tant: jury		* 4 □ Donation 5 □ Other (5			Cen	etery				ing, Maryland
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 Is marked any injury or other traumatic a ARGS.		21. Signature of Funeral Service	Licensee	0	22 F	Name and Address	ss of Facility Collin	ns Funera	1 Home Inc	
_	0 □ = e o		Damis <	F pp.	Ly		0 Univers	sity Bl	vd, W, Si	lver Sprin	g, MD 20901
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications only one caus	that caused the se on each line.	death. Do not ent	er the mode of dyin	g, such as card	iac or respiratory arr	rest,	Approximate Interval Between
-	, nysician		Immediate Cause (Final disease or condition		Osti	Pomul	1145	with	CODSIS		Onset and Death
	/Medical		resulting in death)		Due to (or as a co	onsequence of):		-			1111011111
в	Examiner		Sequentially list conditions,	b	Dia	beter_	mell	Ltus .			
	D #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	"	lue to (ui as a co	msequence of):					
	acute and trans	am	that initiated events resulting in death) Last	c.	Hino	Sarco	_				
90,	sian siurial		rosatting in doath) cast	,	Due to (or as a co	insequence of):					
8760,	death certificate be executed e attending physician and d for use as the buriat-transit	dlcal		d.							
9	ertific ling p	Me	IF FEMALE:	1							
Вох	eath certif attending for use at	an/	23b. Was decedent pregnant in the past 12 months?	10	es, outcome of pr Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of de Month	elivery Day Year
	ne dea the a hed f	Sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		Pregnant at time Unknown	of death 5	Other (specify)			World	Day
<u>o.</u>	by by tac	Physician/Me				-		- 1- P- 41	00- Bida-		
Ś	ign be	by	Part II. Other significant condition	ons contributi	ig to death but no	ot resulting in the di	idenying cause give	эп іл Рап І.		bacco use contribute	
Vital Records,	v requir	Completed							1 Q Y	es 2⊡UMO 3∏F	robably 4 Dunknown
ec	aw as b	ple							24a. Was a autops	sy prior to	utopsy findings available completion of cause of
<u> </u>	Th ate pag	Son							perfór 1 ☐ Yes	med? death? 2☐Ho 1☐Ye	
ita	yalcian: Th is certificate director, pag	Be (	25. Was case referred to medica examiner?					26. Place of D	eath Check only or	10	
of V	S S	2	1 Yes 2 No	Hospital	: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Othe	er: 4 ursing	Home 5 Reside	ence 6 Other (Spe	ecify)
	ng Ph Iter th neral	:uc	27. Manner of Death  17 ■ Natural 5 ■ Pendir		Date of Injury (Month, Day Yes	ar) 28b. Time of Injury	28c. Injury Work	at c?	28d. Describe he	ow injury occurred	
0 0	Attanding ar death. rector: After by the funer	atle	2 Accident investi	gation			M 1 🗆 Y	Yes 2□No			
Division	r Att	Certification:	3 Suicide 6 Could 4 Homicide determ		Place of Injury - building, etc. (S	At home, farm, stre	eet, factory, office		28f. Location (Si City or Town	treet and Number or F n, State)	lural Route Number,
	ital or rs afte al Dir	Cer		1			_		W.		
	To the Hospital or Attanding I within 24 hours after death. To tha Funaral Director: After completely filled in by the funer		29a. Certifier 1 Certifyir (Check only 2 Medical	ng Physician: Examinar: Or	To the best of my	y knowledge, death	occurred at the tim	ne, date and pla	ce, and due to the coursed at the time	ause(s) and manner a late and place, and du	s stated.
	the I	Medical	one)	an	d manner stated.						
_	To To	2	29b. Signature and title of certifie	D 11		110	29c. License	number		9d. Date signed (Mon	th, Day, Year)
	2		Loulen	rum	nmau	My MD	1259	1524		10 VOV	2004
			30. Name and address of person	who complete	d cause of death	(Item 23a) (Type,	Print)	1	1	- 000	2.00
					1,3110	Gracef	eld Koc	id, SI	luer Spri	ng, MID	20904
	Sta		31. Date filed (Month, Day, Year)		32. Registrar's S		Ano. V	/	,		
	Registr	ar	NOV 1 2	2004	1	~	pyveres				

Division of Vital Records, P.O. Box 68760,

		State of Maryland / Department		•	
			rtificate of Death		2004 37833
Physici	an	1. Decedent's Name (First, Middle, Last)  JOSEPH JAMES O'E	RRTEN	2. Date of Death Month	Day Year 3. Time of Death
/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	NOV. 8	, 2004 9:50 P <sup>M</sup> 4c. County of Death
	Ü	CARROLL HOSPITAL CENTER	WESTMINSTER		CARROLL
Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 1. Age (In yrs. la	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	
yland		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Loc	ocation		10d. Inside City Limits
death with the Maryland ms 23e or 28e-f show	Funeral Director	MD. CARROLL WESTMIN			1 ☐ Yes 2X No
with the	i Dire	10. Street and Number 1039 OLD MANCHESTER RD.	10f. Zip Code 21157	10g	Citizen of What Country?
death	nera		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
s after	by Fu	1 ☐ Never Married 2 🕅 Married 1 🖾 Yes 2 ☐ No K ∩ 🕞 F 🔼 🚺	1 ☐ Yes 2 No Specify:	rican, etc.,	Black, White, etc.  Specify: WHITE
2 hour		15. Decedent's Education 16a, Dece	dent's Usual Occupation	. 16	b. Kind of Business/Industry
ithin 7 ne. hen "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired) 'RONICS ENGINEE!		ANUFACTURING
filed w Hygier other th		12 2 EDECT		(First, Middle, Ma	
uld be Aental rked c	To Be	JOSEPH A. O'BRIEN		NA NOONA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiene Importent: if item 27 is marked other then "naturel", or liems 23e or 28e-f show any injury or other treumetic event. It we Medical Evalution into the coulding an once.			ng Address (Street and Number or Rura OLD MANCHESTE		CCMATNOMED MD
s 1 and f Healt item 2 other	3	20a. Method of Disposition 20b. Place of Dispo		7	c. Location - City or Town, State
Page ment o ent: If ury or		1 □ Burial 2 © Cremation 3 □ Hemoval from State 14 □ Donation 5 □ Other (Specify) ALL COUNT	Y CREMATION 11,		
permit. Departimport			2. Name and Address of Facility ${ m FLI}$ $54~{ m E}_{ullet}$ MAIN ${ m ST}_{ullet}$		UNERAL HOME INSTER, MD. 21157
		23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest	, Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	spiraton Face	line	Onsol and Board
Examiner		Due to (or as a consequence of):	Sensis		
ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disage or injury)	1	. 0	
te be executed ysiclen and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):	4	tula	
ate be hysicle the bur	licai	d. Abdomina t	tarte Anewyon	repa	1
leath certificate attending phys I for use as the	/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
death	Physician/M	in the past 12 months?  1 Yes 2 No  1 Live birth 2 Fetal death 3 Leave and 4 Pregnant at time of death 5 Leave and 1 Leave and	Ectopic pregnancy Other (specify)		Month Day Year
es that the death igned by the atte be detached for	Phys	9 ☐ Unknown   SE Officion  Part II. Other significant conditions contributing to death but not resulting in the u	nderkring cause given in Part I	23e Did tobac	co use controute to the cause of death?
The law requires that the death certificate ate has been signed by the attending phys page 2 should be detached for use as the	ed by	Renal Failur	noonying cause given in Fart.	1 Tes	2 No 3 Probably 4 Unknown
e 2 sho	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
relcien: The law s certificate has b lirector, page 2 s		25. Was case referred to medical	00 Pl (P. 11	performer	
yelcie is cert directe	To Be	examiner?  1 Yes 2 Note: Hospital: 1 Impatient 2 ER/Outpatien	Othor	n (Check only one) me 5 ☐ Residence	e 6 □Other (Specify)
Ing Ph		27. Manner of Death 1 Deatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time o	Work?	28d. Describe how	injury occurred
Attend death ctor: / y the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str	M 1 Yes 2 No	28f. Location (Stree	at and Number or Rural Route Number,
tel or / rs after el Dire ed in b	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	State)
To the Hospitel or Attending Phyelcien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai	29a. Certifier  (Check only one)  1 Sertifying Physician: To the best of my knowledge, deatled the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the caused at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
Totl comp	Ĕ	29b. Signature and the discoulier Child M.D.	D - 00 54 2	(8   29d.	Date signed (Month, Day, Year)
Markey	(8)	30. Name and address of person who completed cause of death (Item 23a) (Type, DR. Ruman B Keinera, 34	Print Malenty Lu	re, We	1-09-04 17 minster MD 21157
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature		,	
Registr		NOV 1 0 2004 Server &	goerle		

			For State Registrar	State of	Marylan		artment o			ental Hygi	ene 0 4	37834
			1. Decedent's Name (First, Middle,	Last)						2. Date of Death	1	3. Time of Death
	Physici /Medic		Doris Herbo:	rg Olese	n					Month Nov.	Day Y	10:30 a <sup>M</sup>
	Examir		4a. Facility Name (If not institution,	-	ber)		4b. City, Tow	n, or Loc	ation of Death		4c. County of	
			474 Retford	Drive					na Par	k	Anne	Arundel
	Funeral		Social Security Number	5. Sex 7. 1 ☐ M 2 🛣 F	. Age (In yrs.		If Under 1 Ye Months Da		ours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		560-66-9411 Usual Residence of Decedent	TE IN ZUAT	64	Yrs.				Mar. 30		Denmark
	land ow		10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits
	Marylan f show	ğ	MD Anne A	Arundel		S	Severna	Park	ς			1 ☐ Yes 2 X No
	288	Director	10e. Street and Number				10f. Zip Cod	8		10	g. Citizen of Wha	ut Country?
	3a o		474 Retford Driv	ve				21146	5		US	
	death	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.	.S. 13. \			ic Origin? (Specestican, Puerto F	cify Yes or No-	14. Race	American Indian,
9	after or Ite	F	1 Never Married 2 Marrie				r res,sp <i>ec</i> πy d 1 □ Yes 2 <del>[</del> 2]1			rican, etc.)		White, etc. White
21215-0036	d within 72 hours after death with the Maryland piene. rr then "naturel", or tems 23a or 28a-f show the Modical Examiliter matter modified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date	es:		1 1 1 1 8 2 <u>2 2 2 1</u> 1	<b>4</b> 0 3p	ocity.		Specify:	
5-	natu	Completed	15. Decedent's (Specify only highest)	Education grade completed)		(Give	tent's Usual Oc kind of work do	ne durino	most of working	g 1	6b. Kind of Busin	ess/Industry
12	withir	m d	Elementary/Secondary (0-12)	College (1-4	for 5+)	1	OO NOT use re	,	mptrol1	025	7	1. d
2	THE PARTY NAMED IN		17. Father's Name (First, Middle, La	2		770	Courtai				Accoun	ting
an	d be ental ced o	o Be	Carl Georg Olese							ederson	aiden Jumame)	
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, It's M.	ို	19a. Informant's Name/Relationship	p (Type, Print)		19b. Mailin	ng Address (Stre				City or Town, Sta	te. Zio Code)
	27 rtr		Terri Stewart/Da	aughter							ck, MD	
Jre,	of Heal		20a. Method of Disposition			face of Dispo	sition (Name of natory or other)		Da	ite 2	0c. Location - City	
Ē	Page nent c		1 ☐ Burial 2 ☑ Cremation 3  1 ☐ Donation 5 ☐ Other (Spe		ate		remator	,	Nov.	.8, I	Baltimore	e, MD
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Buneral Service Lin	nsee Common and the c		B	Name and Adarranco	dress of	ons, P.	A. Sevei	rna Park	Funeral Home
			23a. Part1. Enter the disease, or co	omplications that cau	sed the death	n. Do not ente	er the mode of o	tying, su	ch as cardiac or	y Sevel respiratory arres	ma Park	MD 21146 Approximate
(	Physician		Anock, or heart failure. List or Immediate Cause (Final	ily one cause on eac		11.4.	1-		PISS			Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a. Due to (or	as a consequ	JAW uence of);	1110	ry	16136	1950		
	Examiner		Consensation by the annuality of	h								
	p =	ner	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	vanea of).						
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с.								
30,	sate be executed obysician and the burial-transit		resulting in death) cast	Due to (or	as a consequ	uence of):						
8760,	icate be executed physician and s the burial-transit	dicai		d								
9 ×	eath certifi attending p	/Me	IF FEMALE:	23c. If yes, outcome	me of pregna	nev						
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	h 2 ∏Fetal nt at time of de	death 3	Ectopic pregna				23d. Date of Month	delivery Day Year
o.	that the de ed by the detached	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9 Unknow		adii 5	(Specily)					
Ω.		by Physician/Me	Part II. Other significant conditions	s contributing to deat	th but not resu	ulting in the un	iderlying cause	given in l	Part I.	23e. Did toba	icco use contribut	e to the cause of death?
Records,	quires n sign uld be	q pe	DIANSTOS							1 🗆 Yes	2.XNo 3[	Probably 4 Dunknown
CO	aw requir as been si 2 should	olete	ityporupi.	DomiA						24a. Was an	24b. Were	autopsy findings available
R	The lav	Completed								autopsy	prior deati	to completion of cause of h?
Viital		a	25. Was case referred to medical					26.	Place of Death	1 Yes 2) Check only one	<del></del>	Yes 2□ No
	Physic this ce al direc	To B	examiner? 1 ☐ Yes 2 2 0	Hospital: 1 ☐ Inp.	atient 2 1	ER/Outpatient	3 □ DOA	Other: 4	☐ Nursing Hom	e Masiden	ce 6 Other (5	Specify)
0	ding PI h. After th funeral		27. Manner of Death	28a. Date of I (Month,	Injury Day Year)	28b. Time of Injury	28c. In	jury at vork?	28	ld. Describe how	injury occurred	
sio	ttendi death. stor: A / the fu	catle	2 Accident investigat				M 1	Yes	2 🗆 No			
Division of	I or At after d Direct I in by	Certification:	3 Suicide 6 Could not 4 Homicide determine	al 286. Place of	Injury - At ho , etc. (Specify	me, farm, stre	et, factory, offic	е	28	If. Location (Stre City or Town,		r Rural Route Number,
	pital ours a eral [		00s Cartillas (5) delicina	Dhardeles Tour		4-4						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)  1 Certifying 2 Medicel Ex	Physician: To the base aminer: On the base and manner	s of examinat	ion and/or inv	occurred at the estigation, in m	time, da y opinion	te and place, ar , death occurred	d due to the cau I at the time, dat	se(s) and manner e and place, and	r as stated. due to the cause(s)
	To t Withi Comp	Σ	29b. Signature and title of certifier	۸ .			29c. Lice				d. Date signed (M	
			1 S-/ tuni	سال	NO		D	416	88	11	108/2	you
			30. Name and address of person which the street of the str	LTUN. M	of death (Item	23a) (Type, F	Print) 2 ferse	HW	54.4	ou, An	napolis	mo 24401
	Sta Registr		31. Date filed (Month, Day, Year)	2004 32. Jegi	istrar's Signat	K. L	sile.					

State of Maryland / Department of Health and Mental Hygiene 0 14 Certificate of Death

37835

						Cei	illicate C	יו נו	zau i	0.0-1	Reg. No.		1
ı	Physician /Medical	1.0	me (First, Middle, Last)  RAY PHILLIP	_				_		2. Date of De Month October	31, Day 2004	Yeer	3. Time of Death 11:30 PM
	Examiner	-	(If not institution, give		)				City, Town, or Lo	ocation of Deat	th 4c. County	of Deeth	
			terlee Place A				If Under 1 Ye		Under 24 Hrs.	0.0 (.0)			(2)
	Funeral Director	5. Social Security 241–74–216	58	7. A	ge (In yrs. li 59	ast birthday) Yrs.	Months Da		Hours Min.	8. Date of Bi (Month, Di 07/01/1	rtn ay, Yeer) 1945	Coun	lace (State or Foreig try) rolina
	and	Usual Residence 10a. State	10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City Limits
	Maryl she led a	MD	Mantgaren	v	Silv	er Sprij	nos						1√2 Yes 2□No
	r 28a	10e. Street end N		2			10f. Zip Coo	le			10g. Citizen of	What Coun	try?
	3a o	8301 Easte	em Avenue								United S	tates i	America
	ifter death with the Main terms 23a or 28a-f signer must be notified.	11. Marital Status		12. Was Decedent Armed Forces	Ever in U,	S. 13. V	Vas Decedent	of Hispe	enic Origin? (Sp Mexican, Puerto	ecify Yes or No	o- 14. Ra	ce - Americ	
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		rried 2□ Married 4 ☆Divorced	1 Yes 2 X If Yes, Give Year or Dates:	₹No		☐ Yes 2[X]		Specify:	Thour, sto.		y: Blac	
5-0	72 h natu dical	(Spi	15. Decedent's Edu- ecify only highest grade	cation completed)		16a. Deced (Give	ent's Usuel Ockind of work do	cupatio	n ing most of work	ing	16b. Kind of B		*
121	within han m	Elementary/Sec	, , ,	College (1-4or	5+)			tired)			George '		gtan
d 2	Hygie Hygie Ither t	17 Father's Name	e (First, Middle, Last)			Super	visor	18	. Mother's Nam	e (First, Middle	Hospit , Maiden Sumar		
an	d be fill H antal H cod out		e Phillips							he Baker		,	
<u></u>	should marke marke		Name/Relationship (Ty	pe, Print)		19b. Mailin	g Address (Str	eet and			oer, City or Town	, Stete, Zip	Code)
Maryland	nd 2 suith ar 27 is r trau		Ll - Daughter			1330 -	- 7th Sta	æt,	N.W. #61	5; Washi	ngtan, D.	C. 200	001
ē,	s 1 a f Hear ftern othe	20a. Method of Di	•		CE	ace of Dispos	sition (Neme o	f nlace)		Date	20c. Location	City or To	wn, State
E	Page lent o		2 □ Cremation 3 □ R ⊾ 5 □ Other <i>(Specify)</i>	emoval from State			morial Pa		1	1/08/04	Landov	er, Mai	ryland
Baltimore,	mit.	21. Signature	uneral Service Licens	^	- 30		Name and Ac			~			
m	Depermine any in poor	) W	undound	Soonin	W)	,			al Service Suitland		nd 20752		
		23a. Part 1. Hnter	r the disease, or compli eart failure. List only	tions that cause	d the death	. Do not ente	or the mode of	dying, s	such as cardiac	or respiratory a	arrest,	1	Approximate Interval Between
	Physician	SHOCK, TOR	sart failure. List offig si	ie cause on each i	iiiio.							1	Onset and Death
7	/Medical	Immediate Cause disease or condit	tion _	Metas	static	Lung (	Cancer					1	
	Examiner	resulting in death	i) a			es a conseq							
	sit ed			)									
	The law requires that the death certificate be executed ate has been signed by the ettending physician end page 2 should be deteched for use as the buriel-transit completed by Physician/Medical Examiner	Sequentially list of	conditions, immediate		Due to (or	es a conseq	uence of):						
Box 68760,	be ed lician burie	Sequentially list of if eny, leading to cause. Enter Unicause (Disease of Cause of Cause (Disease of Cause of C	derlying or injury									i	
687	icate phys s the	that initiated ever resulting in death	) Last		Due to (or	as a consequ	ience of):						
×	certification of the sales a			i									
		Part II Other sign	nificent conditions con	tributing to death h	nut not resu	lting in the ur	derlying cause	given i	in Part I	23b. Did	tobecco use co	ntribute to	the cause of deeth
P.O.	The law requires that the destate has been signed by the el. page 2 should be deteched it. Completed by Physic	Tak II. Other sign	micon conditions	tinbuting to douth i	out flot food	iling in the di	idony ing oddoo	giroii			Yes 2□ No		
	s that												·
of Vital Records,	en sig									24a. Was	s an autopsy ormed?	ava	ere autopsy findings allable prior to
ည္မ	has be ge 2 sh mplet											of o	npletion of cause death?
æ	ysician: The lav is certificate has director, page 2 fo Be Comp									+0	¥35 2 <b>X</b> No	10	Yes 2□ No
İta		25. Was case reference:	erred to medical					20	6. Place of Deat	h (Check only	one)	1	
<u>&gt;</u>	Physician: rthis certific and director, TO Be	1 ☐ Yes 2	XI No ⊢	lospital: 1   Inpati	ient 2 🗆 I	ER/Outpatien			4□ Nursing Ho	me 5□Res	idence 6XIOti	ner <i>(Sp</i> ec <i>if</i> )	/ Hospice
ū	ng Pl	27. Manner of Dea	ath 5 ☐ Pending	28e. Date of Inju (Month, Da	ury ay Year)	28b. Time <i>o</i> f Injury		njury et Work?		28d. Describe	how injury occur	rred	
sio	Attending or death. ector: After by the fune	2 Accident							3	00(1)	(011		(Deute Number
Division	or Att	4 Homicide	dotorminod	28e. Place of In building, e	ijury - At h <i>o</i> tc. <i>(Sp</i> ec <i>ify</i>	me, farm, stre )	et, factory, off	ice		City or To	(Street and Num wn, State)	oer or Hure	i Houte Number,
	ne Hospital or Attending PI nn 24 hours after death. The Funeral Director: After the pletely filled in by the funeral pletely filled in by the funeral edical Certification:	29a. Certifier	1 Cartifulna Phys	sielen. Te the best	-6 les	uladaa dooth	accurred at th	o timo	data and stone	and due to the	cauca(s) and m		atad
	Hos 24 hc Fun etely	(Check only one)	1☐ CertifyIng Phys 2☐ Medical Examir		of examinati								
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	29b. Signature er	nd title of certifier	A			29c. Lic	ense ni	umber		29d. Date signe	d (Month,	Day, Yeer)
	- s + ō	•	mitt	The Fru	2.111	17	NO	05	9855		Nov.	11, 2	004
	(n)	30. Name and ed	dress of person who co	mpleted ceuse of	death (Item	23a) (Tvoe I	Print)					, , ,	7
) 1	3)	0	200, M.D.	5601 La	h Ro	Wen B	Ivd Pr	of o	ffice Bld	9 Ste 3	03. Ba	(to, 1	11) 21239
	State	31. Date filed (Mo	onth, Day, Year)	32. Regist	rar's Signat	ure	- )			)			
	Registrar	NO.	V 1 2 2004	Mary	. K	ha	1.						

10a, State

MD.

5. Social Security Number

158-16-7713

10b. County

CARROLL

Usual Residence of Decedent

1 □ M 2√2 F

10c. City, Town or Location

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Month IRENE GLADYS PEREGO NOV. 10, 2004 7:58 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CARROLL HOSPITAL CENTER WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 89 NEW JERSEY 7/27/1915

10d. Inside City Limits

Approximate Interval Between Onset and Death

USA

Month

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

11/11/2004

Year

21157

14. Race - American Indian, Black, White, etc.

Specify: WHITE

1 ☐ Yes 2 No

**Examiner Funeral** 

**Physician** 

/Medical

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. It is Madical Examble 1, ust by ruiting at nd Mental Hygiene. marked other than . Pages 1 and 2 should be fil ment of Health and Mental H lant: If item 27 is marked ott injury or

RENE CLADYS

Physician /Medical Examiner

Examiner

ģ

Completed

Certification:

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Franca K.

burial-transit The law requires that the death certificate be executed attending physician Box 68760 the. Records, P.O. Division of Vital After To the Hospital or Attending death. Director: after within 24 hours a WIL

Director FINKSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2717 LAWNDALE RD. 21048 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X No þ 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE 12 HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) THOMAS FRANCIS CAMPBELL, SR. MARY FRANCES DICKERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDERICK T. PEREGO - SON 2717 LAWNDALE RD., FINKSBURG, MD. 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation \_ 5 ☐ Other (Specify) LOUDON PARK CEM. 11/15/04 BALTIMORE, MD. al Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Immediate Cause (Final IN MACCER-CBRAL nemorrhage disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗆 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Registrar

Blown & Joseph

Gales of

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS K. GALVW TY

29c. License number

D31660

29, STONER AVENUE LIES MINISTER

			For State Registrar		State of Ma	aryland /	/ Depa	artment of I tificate of	Health <i>Death</i>	and Me	ental Hy	gien Reg. N	200	4	3783	7
	Physici /Medi		1. Decedent's Name (	(First, Middle, Las Harry P	•					2	2. Date of De Month		ay (	Year.	3. Time of Deat 2330	
	Examir		4a. Facility Name (If r. Sacredo	Hear	+ Hospi	la l	birthday)	4b. City, Town,  If Under 1 Year	1ber	ar 24 Hrs.	3. Date of Bi	4	County	2Q(	place (State or For	
	Director		216-05-95 Usual Residence of D	1 00	<b>X</b> M 2□ F	90	Yrs.	Months Days	Hours		Month, Da	2,19	14	WV	intry)	_
	Maryland -f show Iled et	tor	1	10b. County Mineral		10c. City, T Keys		cation							10d. Inside City Lin XXYes 2 □	
	th with the 23e or 28e unt be noti	Funeral Director	10e. Street and Numb 82 Spring					10f. Zip Code 267	'26			10g. C	itizen of V		ntry?	
920	72 hours after death with the Maryland "natural", or items 23e or 28e-f show clear Examinations.	þ	11. Marital Status  1 Never Married 3 XWidowed 4		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		1	Vas Decedent of f Yes, specify Cub I ☐ Yes 21⁄2 No	oan, Mexica	an, Puerto Ri	ify Yes or No ican, etc.)	0-	Blac	e - Ameri k, White, hite		
21215-0036	.9 2	Completed	(Specify Elementary/Second	15. Decedent's Ed y only highest graduary (0-12)	ucation de <i>completed)</i> College (1-4or 5		(Give	lent's Usual Occu kind of work done OO NOT use retire	durina mo	st of working	7	16b.	Kind of Bu			
nd 21	be filectal Hyg	Be Con	12th 17. Father's Name (Fi				pipe	fitter		ner's Name (		, Maide		_	Mill	
Maryland		2	Harry S.  19a. Informant's Nam		vpe. Print)	1	19b. Mailin	g Address (Stree		na M.			or Town	State Zin	Code)	
	s 1 and 2 should f Health and Mer item 27 is marke other treumetic		Bona J. H		•			James St						01410, 23,	, 0000)	
Baltimore,	00-		20a. Method of Dispo 1   ↑ Burial 2   ↑ 4 □ Donation 5	Cremation 3 🗆	Removal from State )	ceme	etery, cren	sition (Name of natory or other pla intCemet	′ 1	Dat			ocation. /ser,		own, State	
Balt	permit. Pag Department Importent: I eny injury o once.		21. Signature of Fund	eral Service Licen.	Nofrin	ser	, M	Name and Address  Name and Add	Funer	al Hon	ne, In	c. 2672	26			
	Physician		Immediate Cause (Fi	failure. List only	lications that caused one cause on each li	the death. Inc.									Approximate Interval Between Onset and Death	. [
	/Medical Examiner	J.	resulting in death)  Sequentially list cond	ditions,	b. Due to (or as	Lemo	wh	cegic	calei	ma	±1.7	/			7 day	'_
Vi	sician and burial-transit	Examiner	if any, leading to immicause. Enter Underly Cause (Disease or in that initiated events resulting in death) La		c. Due to (or as	letas	tole	Conc	et c	o/ Ca	0/021	P			, pts	
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.O. Box (	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1  Yes 2 1 9 Unknown	ionths?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea	ath 3	Ectopic pregnand Other (specify)	ey				23d. Date Mor		ery Day Year	
Δ.	The law requires that ite has been signed b oage 2 should be deta	by	Part II. Other significa	ant conditions co	ontributing to death b	ut not resultin	g in the ur	derlying cause gr	ven in Part	1,	1	tobacco Yes 2		ibute to t	ne cause of death?	vn
I Records,		Completed				_					24a. Was auto perfo 1 Yes		p	Vere auto rior to co leath?	psy findings availai mpletion of cause of	ole if
Vital	Physicien: this certifica al director, p	o Be (	25. Was case referrer examiner? 1 ☐ Yes 2 ☑ No		Hospital:			oti	hor	e of Death (		one)	120			. 1
ion of	ding h. After funer		27. Manner of Death  1 Natural  2 Accident	5 Pending investigation	1 Inpatie 28a. Date of Inju (Month, Da	ry 28t	Outpatien b. Time of Injury	28c. Inju	ry at		d. Describe				y)	
Division	Dir.	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injuding, etc.	ury - At home, c. (Specify)	, farm, stre	eet, factory, office		28	f. Location ( City or To	Street a wn, Stat	nd Numbe e)	er or Rura	l Route Number,	
	ne Hospitel 124 hours a ne Funerel I	Medical (	29a. Certifier 1 (Check only 2 one)	Certifying Phy	rsician: To the best iner: On the basis of and manner sta	f examination	dge, death and/or inv	occurred at the ti estigation, in my	me, date a opinion, de	nd place, and ath occurred	d due to the at the time,	cause(s date an	and mar d place, a	nner as s ind due to	tated. the cause(s)	
)	To the within 2. To the Complete	Me	29b. Signature and tit	tle of certifier	as /			29c. Licens	se number	77		29d. Da	_		Day, Year)	
	8		30. Name and addres	s of person who o	ompleted cause of d	_ /	a) (Type, 1 2R11		m 136	RLAN	10 ano	1.	715	02		
	Sta Registi		31. Date filed (Month,		32. Registr	ar's Signature	4	A								
DH	MH 17 Rev 1/2	001	N	OV U U ZI	104 /04	OF	RIGINA	Apor	ls !							

State of Maryland / Department of Health and Mental Hygien 2004 37838 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** rederick 0 2000 November /Medical tersor 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) Baltimore If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 **X** M 2 □ F Months Days Min. Hours Yrs 215-56-4906 Director 50 7. 1954 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County ! show 10d. Inside City Limits s 23a or 28a-f shor 1 ☐ Yes 2 ☑ No Funeral Director MD Charles Newburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12402 Chanelview Dr. 20664 death U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) WILLIAM TO 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned 1 □Yes 2 No Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or eny injury or other traumatic event, the Moutel Exp., once. 1 ☐ Yes 2 X No Š If Yes, Give Year or Dates: Specify. Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Building Supply Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Peter Peterson Edythe Siiri Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Barnard - Wife 12402 Chanelview Dr., Newburg, MD 20664 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem. Gardens 11-22-2004 Waldorf, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01391 F Hapl Huntt Funeral P.O. Box 156, Home Waldorf, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner rsician and burial-transit The law requires that the death certificate be executed P.O. Box 68760, physi the b MONTHS for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 DEctopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1□ Yes 2□ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 2 XVo To the Hospitel or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2XNo 1 🗌 Yes 1 atient Medical Certification: To 2 ER/Outnatient 3 DOA After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) B.S. Tesh IMD November, 16,2004 00058078 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B met Balhmore MD 21 SILESHI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 3 0 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For	State of Ivia	ryland	/ Depa	artment of I	realth and	mentai Hyg	gien	0.01	37839
			1 - State Registra MEND ITEM						H F	Reg. No.	0 0 1	01000
	Physicia	an	1. Decedent's Name (First, Middle, La	ist)			, 8	-,,	2. Date of Dea Month	Day		3. Time of Death 12:42A M
	/Medic		Norma Campl  4a. Facility Name (If not institution, giv				4b. City, Town,	or Location of Deat	Novembe:		County of Death	
F	LAdilliii		Springhoues Assist				Bethesda	1		Мо	ntgomer	у
	Funeral		5. Social Security Number 6. S	Sex 7. Age 1 □ M 2/53/F	(In yrs. las	t birthday) Yrs.	if Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	(Year)	9. Birth	plece (State or Foreign intry)
	Director		228-14-3147 Usual Residence of Decedent		81	113.			Mar. 26	, 19	23 Virg	11114
nyland	show det	_	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2\(\frac{1}{2}\)No
he Ma	28a-f.	Directo	Virginia   Fairfax		Alexa	ndria	10f. Zip Code		1	10a Citi	zen of What Cou	
1215-0036 within 72 hours after death with the Maryland	ntal Hygiene. nd other than "natural", or Items 23s or 28s-1 show event, the Madical Extending roughts notified at		6903 Columbia Driv	ve			22307			U.S.		uniy :
death	ems 2	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13.	_1	Hispanic Origin? (S an, Mexican, Puer			14. Race - Ameri Black, White	
36 s after	, or le	by Fu	1 ☐ Never Married 2 ☐ Married  XXXIVidowed 4 ☐ Divorced	1 ☐ Yes ŽŽNo If Yes, Give Year or Dates:			1□Yes 🛣 No				Specify:	ite
2 hour	SalEs	ted t	15. Decedent's E	ducation		16a. Deced	dent's Usual Occup	pation		16b. Ki	nd of Business/Ir	
<b>215</b> ithin 2	Mad "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+		life. I	DO NOT use retire	during most of wo. d)	rking			
d 21	Hygiene other tha	Cor	17. Father's Name (First, Middle, Last	2		Nurse	3	18. Mother's Nar	ne (First, Middle,		1th Car	e
ld be	marked of	To Be	Raymond Campbel		OND (	CAMPBI	ELL		11 EDNA			
ary	and M		19a. Informant's Name/Relationship (	Type, Print)				and Number or Ru				
B, K	of Health a Item 27 is other trac		William Rimm - S	Son	20h Plac		Snowhill sition (Name of	Court,			yland 20	
nor	nt of H		20a, Method of Disposition 1 □ Burial 2 □ Cremation 3 □		cerr	netery, cren	natory or other pla	Nove	mber			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours af	Department of Health and Menta Important: If Item 27 is marked any injury or other traumsite events.	H	*4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice		Moun		. Name and Addre	etery 12 ess of Facility	, 2004	Ате	xandria	, Virginia
m š	Depa Impo any ir	y 11	Syana 2	Zer	D						hington	St, Alex, V
\$5. d			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused to one cause on each line	he death. ). MTT:/1	Do not ent ΓΔ CTΔ′	er the mode of dyi $\Gamma IC \;\; COLOI$	ng, such as cardia J CANCER	or respiratory arr	est,		Approximate Interval Between Onset and Death
	ysician Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	0/6	26	meet	y y i i i i i i i i i i i i i i i i i i				
Ex	aminer		Conventially list conditions	b								
, p <sub>0</sub>	sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a	curisbquer	ice vi).						
760, le be executed	attending physician and for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequer	nce of):						
760, te be ex	ysicia ie bui	cal		_ d								
x 68 entifical	ling ph east	Med	IF FEMALE:	00. 14								
Box eath cert	attend for us	by Physician/Medi	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o  1 Live birth 2  4 Pregnant at ti	☐Fetal de	eath 3	Ectopic pregnanc Other (specify)	4		2	3d. Date of deliv Month	ery Day Year
P.O.	ed by the a detached f	hysi	1 □ Yes 2 🕅 No 9 □ Unknown	9□ Unknown								
	igned be det	by P	Part II. Other significant conditions of	contributing to death but	not resulti	ng in the ur	nderlying cause gr	en in Part I.				the cause of death?
Ord	should	Completed								es 25	1	bably 4 Unknown
Rec Be law	has 3e 2	dmo							24a. Was a autops perform	sy med?	prior to co death?	opsy findings available impletion of cause of
ital	certificate rector, pag	0	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes :	2 🔀 No 18)	1 Yes	2LI N0
of Vita Physician:	this ce	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient		VOutpatien		4 19 Nursing F	lome 5 Reside			(y)
on o	h. After funera	tlon	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day		Bb. Time of Injury	Wo	yat k? Yes 2 □ No	28d. Describe ho	ow injury	/ occurred	
Division of Vital Records, I or Attending Physician: The law requires t	after death Director: in by the	Certification:	3 Suicide 6 Could not b	O Olean of Joine	y - At home	e, farm, str			28f. Location (St City or Town			al Route Number,
Division Hospital or Attending	within 24 hours after death. To the Funeral Director: After this certific											
Hosp	24 hours a Funeral etely filled	Medical	29a. Certifier  (Check only 2 Medical Examone)	nysician: To the best of miner: On the basis of a and manner state	examination	edge, death n and/or inv	eccurred at the tile estigation, in my o	me, date and place pinion, death occu	i, and due to the ci irred at the time, d	ause(s) ate and	and manner as s place, and due t	stated. o the cause(s)
To the	To the	Me	29b. Signature and title of certifier	/ .	6	7	29c. Licens	se number	VA 2	9d. Date	signed (Month,	Day, Year)
			Carleen	Llina		nes	0101	0323	64		11/15	10 / 22306 dria, Va
7	/ n /		30. Name and address of person who	come lated cause of do-	th (Item 2	3a) (Type.	Print)				00-0-0-0-0	2 22201
2 (	(2)		and the second of the second o	mda MI	1 8	109	Hincon	Falm E	of #500	1 1	Herm	drie 1/2

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

pleas ms

Reeves

NOV 1 5 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NeoNatologiST

32. Registrar's Signature

29c. License number

Shady Grove Adventist Hospital, 9901 Medical Center D. Rockville 2008

29d. Date signed (Month, Day, Year)

November

7, 2004

			State of Maryland / Depar	rtment of Health and Me		4004 3/041
	. —	-	Registrer  1. Decedent's Name (First, Middle, Last)		Reg. 2. Date of Death	No.  3. Time of Death
	Physici		Edward W. Roberts		Nov. 10,	Day Year
	/Medic Examir			4b. City, Town, or Location of Death		4c. County of Death
			Genesis Health Care	LaPlata		Charles
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Manager Davis Harrie 186-	B. Date of Birth	9. Birthplace (State or Foreign Country)
	Director		227-03-2189 14 Yrs.	F	eb. 22,	1920 Virginia
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local	ation		10d. Inside City Limits
	Mary -f sh	ţō	MD Charles White Pla	ains		1 ☐ Yes 2√☐ No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	th with	a D	3700 Fox Hall Place	20695		U.S.A.
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. With Inc. 13. With Inc. 14. Was Decedent Ever in U.S. Armed Forces?	as Decedent of Hispanic Origin? (Speci Yes, specify Cuban, Mexican, Puerto Ric	ity Yes or No-	14. Race - American Indian, Black, White, etc.
36	or It	by Fu	1 Never Married 2 Married 1 Yes 2 No	☐Yes 2 <b>X</b> No <i>Specify:</i>	, , , , , ,	Specify: Black
Ö	72 hours after death with the Maryland naturel', or Herns 23e or 28e-f show Jical Examiner mat be mulfied at	d be	3 (Widowed 4 Divorced Year or Dates: 1950-53	nt's Usual Occupation	4.01-	
7.	n "na	plet	(Specify only highest grade completed) (Give ki	ints Osdai Occupation and of work done during most of working ONOT use retired)	7	. Kind of Business/Industry
21215-0036	filed within Hygiene. other then " ent, ine Ma	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  11 Admini	istrative Assistan <sup>.</sup>	t G	overnment
2	be filed ntal Hygie od other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (I		den Sumame)
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other then "naturel", or items 23e or 28a-f show other traumatic event. The Modical Ext., ither is 15 to in lifted at	2	Edward T. Roberts	Irene Ta		
Nar	2 sh and Is m raum			Address (Street and Number or Rural F		
	1 and 2 Health tem 27 l			Fox Hall Place, Wh		ns, MD 20695  Location - City or Town, State
Jor	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crema	111-17-	2004	
Baltimore,	permit. Pag Department Importent: I any injury o			eterans Cem.	_Ch	eltenham, MD
æ	permit. Departr Importe any inju		21. Signatur a Eural Service Licensee M01391	Huntt Funeral Home P.O. Box 156, Wald	oxf MD	20604
74			23a. Part I. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac or r	respiratory arrest,	Approximate Interval Between
W	Pnysician :		Immediate Cause (Final disease or condition	ens to the		Onset and Death
1	/Medical Examiner		resulting in death)	The production of		
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	sit led	nine	Sequentially list conditions, if any, used to fine clatter cause. Enter Undertying Cause (Disease or injury	dielast=		
	al-trar	Examine	that initiated events c.  resulting in death) Last  C.  Due to (or as a consequence of):	caveres		
8760,	death certificate be executed e attending physician and d for use as the buriat-transit	dical E	d			
9	tificat ng phy as th	ledi				
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ E	ctopic pregnancy		23d. Date of delivery
O. E		sici		Other (specify)		Month Day Year
Ρ.	that the led by th detach		Part II. Other significant conditions contributing to death but not resulting in the und	arheing cause cises in Part I	23a Did tabaca	to use contribute to the cause of death?
of Vital Records,	es pe	d by	, a.c. a.c. a.g. a.c. a.c. a.c. a.c. a.c.	anying cause given in raiti.	1 ☐ Yes	
COL	w requir been s should	lete			24a. Was an	24b. Were autopsy findings available
Re	has has	Completed			autopsy performed	prior to completion of cause of death?
ta	i <b>cien: T</b> h certificate rector, pag	a	25. Was case referred to medical	26. Place of Death (C	Check only one)	M6 1 □ Yes 2 ☑ N6
Į	di S	To B	examiner? 1   Yes 2   Mo Hospital: 1   Inpatient 2   ER/Outpatient	011		6 ☐Other (Specify)
			27. Manner of Death 1 ☐ Matural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury Injury		d. Describe how in	
Sio	Attending or death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be	M 1 Tyes 2 No		
Division	2 2 2 0	ertification;	4 Homicide  determined  28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office 28f	f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	pour fille	O	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death of	occurred at the time, date and place, appro-	d due to the equipo	Ve) and manner on stated
	To the Hos within 24 h To the Fur completely	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investore)  and manner stated.	stigation, in my opinion, death occurred	at the time, date a	and place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)
				D4573	7	11/15/04.
(.	Ded		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	•		
1	1,00		Nirmaladeui Jayanthan, MD , 3328 01d  31. Date filed (Month, Day, Year)  32. Paistrar's Signature	Washington Rd., Wa	aldorf, N	4D 20601
	Sta Registr		NOV 1.5 2004 Signature	set)		
			Set of constitution of			

		_	1- For Amend Item Registrar	24a State of A	Maryland 6 D	epartmen Certificate	iosid e of L	ealth ar Death	nd Mental F	lygien Reg. N	2001	37	842		
	Physic /Medi		1. Decedent's Name (First, Middle, Anthony F. S		ello				2. Date of Month NOV	D	200 <sup>Ye</sup>	r	of Death		
	Exami		4a. Facility Name (If not institution, 9			4b. City,		Location of C		4	c. County of D				
	Funeral Director		5. Social Security Number 138–34–4220 Usual Residence of Decedent	.Sex 7.A 1X∑M 2□F	ige (In yrs. last birtl	hday) If Under Months	1 Year Days	If Under 24 Hours	Min. 8. Date of (Month, Jul.	Birth Day, Yea 17,	1944 <sup>9.1</sup>	Birthplace (State Country) NJ			
	Maryland	tor	10a. State 10b. County	Arundel	10c. City, Town		nold								
	sa or 28s	i Direc	10e. Street and Number 32 Old Sturbric	dge Road		10f. Zip	Code	21012		10g. C					
036	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow dical Evariliner must be rediffed at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces	? <b>≵</b> No	13. Was Deced	lent of His offy Cubar		n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - A	merican Indian, hite, etc.	9		
21215-0036	es 1 and 2 should be filed within of Health and Mental Hygiene. I item 27 is marked other than " r other traumatic event, the Me	Completed	15. Decedent's (Specify only highest to Elementary/Secondary (0-12)	Education grade completed)  College (1-40)		Decedent's Usua (Give kind of wor life. DO NOT us Engi	rk doлe di	uring most of	f working	16b.			ion		
Maryland		To Be C	17. Father's Name (First, Middle, La Anthony Salvato						Name (First, Midd Finamore		n Sumame)				
			19a. Informant's Name/Relationship Karen I. Salvat		.fe	32 Old S	Sturk		r Rural Route Nur Road, Ar						
Baltimore,			20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3  `4 ☐ Donation 5 ☐ Other (Spe		cemetery	Disposition (Namy, crematory or ot nt Mem.	ther place	lens	Nov. 11, 2004				)		
Lakemont Mem. Gardens  1. Signature of Funeral Service Licensee  2. Name and Address of Facility Barranco & Sons, 495 Gov. Ritchie Hwy								nwy, sev	erna	Park F Park,	uneral MD 211	Home 46			
	Physician /Medical Examiner		23a. Pant. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	A PPEA	ed the death. Do not line.  JDICEAC s a consequence of	- ADE						Interval Be Onset and	tween Death		
8760,	ate be executed hysician and the burial-transit	Icai Examiner	Sequentially list conditions, and the conditions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of	7									
O. Box 687	The law requires that the death certificate tie has been signed by the attending phys age 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 ∏ Fetal death at time of death	3 □Ectopic pre 5 □ Other (spe					23d. Date of o	lelivery Day	Year		
ecords, P.	quires that t in signed by uld be deta	by	Part II. Other significant conditions	contributing to death	but not resulting in t	the underlying ca	luse giver	in Part I.	11		tizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: White  Ind of Business/Industry  Construction  Sumame)  Or Town, State, Zip Code)  MD 21012  Docation - City or Town, State  Idsonville, MD  Park Funeral Home Park, MD 21146  Approximate Interval Between Onset and Death  Park Funeral Home Park, MD 21146  Approximate Interval Between Onset and Death  Onset and Death  Park Funeral Home Park, MD 21146  Approximate Interval Between Onset and Death  Onset and Death				
Œ		Completed				· · · · · · · · · · · · · · · · · · ·			24a. Wa au pe 1 □ Yes	topsy rformed?	prior to death	completion of	available cause of		
ion of Vital	Attending Physician: Th r death. ector: After this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner?  1	Hospital: 1 Inpat 28a. Date of Inj (Month, Di	ury 28b. Tir		Other Bc. Injury a Work?	4 🗌 Nursir	Death (Check onling Home 5 > 1 to 28d. Describ	sidence		ecify)			
Division	al or Attens s after death Il Director: od in by the	Certification;	3 Suicide 6 Could not determine	d 28e. Place of it	ijury - At home, farn tc. <i>(Specify)</i>	n, street, factory,	office		28f. Location City or T	(Street ar	nd Number or I e)	Rural Route Nur	nber,		
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying 1 2 Medicel Ex-	Physician: To the bes aminer: On the basis and manner s	of examination and/	death occurred a for investigation,	it the time	, date and pl	lace, and due to the	e cause(s e, date an	) and manner d place, and de	as stated. ue to the cause(	s)		
)	To the h within 24 To the f complete	W	29b. Signature and title of certifier	>, Or	10/09/		License		211			_	204		
			30. Name and address of person wh	DWAY,	BALT	ype, Print) / MO(2.	E,	MA	ZII RYLA	ND	21	231			
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 0	2004 \$2. Regist	rar's Signature	And .			/						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** 8:50AM ELEANOR E. November 15,2004 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 0 4207 Steeds Grant Way Ft. Washington Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF Months Days Director July 9,1920 577-28-5463 Wash. D.C Usual Residence of Deceden death with the Maryland 10a. State 10c, City, Town or Location 10d. Inside City Limits 10b. County Show parmit. Pagas 1 end 2 should be filed within 72 hours eftar daath with tha Maryla Dapartmant of Haalth and Mantal Hygiane. Important: If Itam 27 is marked other than "natural", or flema 23a or 28a-1 show any injury or other traumatic event, the Maddal Examiner must be notified at MITH Fort Washington Prince George's 1 TYPes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4207 Steeds Grant Way USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ₹ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: Black 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ELEANOR Clerk U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Newton Bessie Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4207 Steeds Grant Way, Fort Washington, MD 20744 Darrell M. Smith / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/19/04 Suitland, MD 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 21. Signature of Euneral Service License 4111 Pennsylvania Ave. Suitland, MD 20746 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or as a consequence of). Examiner Hospital or Attending Physician: Tha law raquires that the death cartificeta be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that is its lead of the cause). Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical that initieted events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whiknown EMENTIA þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed POLYMYALGIA RHEUMATICA HYPERTENSION t Yes PPA C 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending aftar death. 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D

complataly filled 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 16th 2004 Nov D0053782 HYSICIAN 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) SUITE # 101, FT. WASHING TON RD-SURESH VERGHESE 11701 LIVINGSTON 31. Date filed (Month, Day, Year) . Registrer's Signature NOV 1 6 2004 Registrar

DHMH 16 Rev 6/95

			1 - State Registrar		artment of Health and rtificate of Death	Mental Hygie	711116	37844				
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death				
	/Medic	al	Maria Anna Steinbreches  4a. Facility Name (If not institution, give street and n		4b. City, Town, or Location of Deat	Nov. 11,	2004 4c. County of Death	9:30 A <sup>M</sup>				
	Examin	er	9122 Friars Rd.	unib <del>o</del> r)	Bethesda		ontgomery					
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth	Birth 9. Birtholace (State or Foreign					
	Director		149-40-2341 ¹□M 2 <sup>™</sup> F	81 Yrs.	Months Days Hours Min.	Jan. 1, 1		tria				
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits				
	Mary I sh	ţō	MD. Montgomery	Bethesda				1 XYes 2 ☐ No				
	h with the	al Director	10e. Street and Number 9122 Friars Rd.		10f. Zip Code 20817	· ·	. Citizen of What Country? USA					
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23e or 28a-f show other treumatic event, the Medical Exertical transite receiling at	by Funeral	Armed F	2 <b>∑XN</b> o iive	Was Decedent of Hispanic Origin? (5 f Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ KNo Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh					
215-0	in 72 ho in "natul Wedical	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12)  College	(Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	orking 16b	o. Kind of Business/Ir	ndustry				
212	ad within giene. er then "	Com	5+	(1-4or 5+) Stati	stician		IMF					
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the Me	To Be (	17. Father's Name (First, Middle, Last) Franz Schuh			<sub>me (First, Middle, Maid</sub> Schachner	den Surname)					
ary	2 shou and N Is mai	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or R	ural Route Number, Ci	ty or Town, State, Zi	o Code)				
	1 and 2 Health tem 27		Nick Steinbrecher / Sor		Rahway Ave.,West							
Baltimore,	permit, Pages 1 and Department of Health Importent: If item 27 eny injury or other tr once.		20a. Method of Disposition  1    1    Burial 2 □ Cremation 3 □ Removal from  4 □ Donation 5 □ Other (Specify)	State	sition (Name of natory or other place)  Heaven Cem. 11/1		. Location - City or T ilver Spri					
Balti	permit, Pages Department of Importent: If it eny injury or c		21. Signature of Funeral Service Licensee	22	Name and Address of Facility Jos	seph Gawler						
*	W 6		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not ent				Approximate Interval Between				
.[0	Pnysician		Immediate Cause (Final	nal Failure			13	Onset and Death weeks				
	/Medical Examiner		esulting in death)  Due to (or as a consequence of):									
		<u></u>		o (or as a consequence of):	noma							
	nted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	(or as a consequence or).								
Ć,	be executed sician and burial-transit	Еха	that initiated events c. resulting in death) Last Due to	(or as a consequence of);								
8760,	rate be	dical	d.									
9	artifica ing ph e as th	Med	IF FEMALE:									
O. Box	that the death certificate be executed ad by the attending physician and detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant 12c. If yes, o	nant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year				
ds, P.	es pe au	Completed by Ph	Part II. Other significant conditions contributing to Hematuria	death but not resulting in the u	nderlying cause given in Part I.		co use contribute to t	he cause of death?				
Record	w requir been si should	lete				24a. Was an	24b. Were auto	opsy findings available				
Re	The law ate has b page 2 sl	omp				autopsy performed 1 ☐ Yes 2€	prior to co death?	mpletion of cause of				
Vital		Be C	25. Was case referred to medical		26. Place of De	ath (Check only one)	10 103	2010				
of V	8 5	10 E		Inpatient 2 ER/Outpatien	t 3 DOA Other: 4 Nursing F	dome 5 🔀 Residence	6 ☐Other (Speci	(y)				
	ding Phy h. After thi funeral	lon:	Taracara Barrana	of Injury 28b. Time of Injury Injury	Work?	28d. Describe how in	njury occurred					
Division	deal deal ctor: y the	licat	2 Accident investigation 3 Suicide 6 Could not be 28e Place	e of Injury - At home, farm, str	M 1 ☐ Yes 2 ☐ No	28f. Location (Street	t and Number or Ruc	al Route Number				
Ω	i Diffe	Certification:	4 Homicide determined built	ding, etc. (Specify)	oot, radiory, office	City or Town, St		ar riodio riomoor,				
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical (	(Check only 2 Medical Examiner: On the	ne best of my knowledge, death basis of examination and/or in nner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the cause urred at the time, date	(s) and manner as s and place, and due t	tated. o the cause(s)				
	To the within 2 To the complex	ž	296. Signature and title of certifier		29c. License number	1	Date signed (Month,	Day, Year)				
			p Lana	~ 10	D32610	11	./12/2004					
R	(12)		30. Nam, and odress of person who completed can T.J. McNamara, MD., 102			20817						
£ 350	Sta Registr		31. Date filed (Month, Day, Year)	Registrar's Signature								

DHMH 17 Rev 1/2001

-			1 - For State Registrar	State of Maryland	Cei	tificate of De	eath	Re	g. No.	37845
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Dorothy Swint  4a. Facility Name (If not institution, give s	street and number		4b. City, Town, or Lo		Volember	10 2004 4c. County of Death	1:57 P M
	Examin	er	Doctor's Hospital	street and numbery		Lanham, M				
	Funeral		5. Social Security Number 6. Sex		t birthday)	If Under 1 Year If		B. Date of Birth (Month, Day,	Prince Ge	place (State or Foreign intry)
	Director			<sup>1M 2</sup> <del>X</del> F 40	Yrs.	Months Days	Hours Min.	Aug 3, 1	1964 News	ark, N.J.
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, 1	Town or Lo	cation				10d. Inside City Limits
	Manyl 1 eho	ō	Maryland Prince Ge			, Maryland				ty∑Yes 2 No
	r 28e	Director	10e. Street and Number	orges Green	IDETC	10f. Zip Code		10	g. Citizen of What Co	intry?
	h with	0	8631 Greenbelt Roa	d		20770			nited State	
	eep .	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of Hispa f Yes, specify Cuban, h	anic Origin? (Spec	ify Yes or No-	14. Race - Amer Black, White	ican Indian,
36	72 hours after deeth with the Maryland naturel; or Items 23a or 28e-f ehow disel Exar. il ar mat be mutified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 27 No	1	v	Specify:		Specify: Blac	
21215-0036	hour	ed b	3√√Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	16a Decec	lent's Usual Occupatio	20	1	6b. Kind of Business/I	
212	nin 72 In "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done duri DO NOT use retired)	ing most of working	'	ou. Kind of Business/f	loustry
212	d within giene. er than "	Com	12		lerio	cal Worker		F	lementary	School
pu	be filed tal Hygid d other event, I	3e	17. Father's Name (First, Middle, Last)			]	3. Mother's Name		,	
yla	2 should be and Mental la marked eumatic ev	2	Walter A. James		-		atherine	70100	on) James	
Maryland	s 1 end 2 should be filed within 72 hours after deeth with the Marylan f Heelth and Mental Hyglene. If marked other than "naturel", or items 23a or 28e-f ehow other treumatic event, if a Mulical Exar, if ar marked ovent, if a Mulical Exar, if ar marked ovent, if a Mulical Exar, if ar marked ovent, if a Mulical Exar, if ar marked ovent, if a Mulical Exar, if ar marked ovent, if a Mulical Exar, if ar marked ovent, if a Mulical Exar, if ar marked ovent, if a Mulical Exar, if ar marked over the marked over th		19a. Informant's Name/Relationship (Ty)		196. Mailir 237 - A	ng Address <i>(Street and</i> Alexander <i>S</i>	Street, N	Houte Number, ( Newark,	City or Town, State, Z. New Jersev	p Code) : 07102
	s 1 end 3 f Heelth item 27 other tre		Catherine James (Mo 20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of	Da	_	0c. Location - City or 1	
E O	Pages nent of I int: If its		1 N Burial 2 □ Cremation 3 □ R  `4 □ Donation 5 □ Other (Specify)	emoval nom State [	-	natory or other place)	11/20/	'04 N	ewark, N.J	ersev
Baltimore,	permit. Pages Depertment of Importent: If I any injury or once.		21. Signature of Funeral Service License	90	22	. Nam and Assess of	1 -			PA 26247
<u> </u>	89559			mons	15	538 MAR	LBURO	Pike.	Forestuil	le, Mid
П	15.		23a. Part1. Ent the disease, or complishock, or leart failure. List only or	cations that caused the death. ne cause on each line.	Do not ent	er the mode of dying, s	such as cardiac or	respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Sephi		ch				Onset and Death
В	/Medical Examiner		resulting in dealth)	Due to (or is a consequer	nce of):	2				100-
		e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	nce of):	nenon	~ =			(1)14
	outed Id ansit	Examiner	Cause. Entar Underlying Cause (Disease or injury that initiated events							
Ó,	e exection ar	Exe	resulting in death) Last	Due to (or as a consequer	nce of):					
68760,	ficate be executed physicien and s the burial-transit	edicai		l						
_	± σ, ε		IF FEMALE:	3c. If yes, outcome of pregnance	1979			1,111		-
Вох	death certifi e ettending I id for use as	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat	ath 3	Ectopic pregnancy Other (specify)			23d. Date of deli-	ery Day Year
P.O.	y the	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
	requires that leen signed b hould be deta	by P	Part II. Other significant conditions cor	tributing to death but not resulting	ng in the ur	nderlying cause given in	in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ord	w require been sig should b		Human	Immunod	efici	eny 1)	isam	1 ☐ Yes	2 2 No 3 □ Pro	bably 4 Unknown
ecc	as b	Completed						24a. Was an autopsy		opsy findings available ompletion of cause of
E 35	ate pag	Con						performe	ed? death?	2 No
of Vital Records,	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		77	6. Place of Death			
ō	Physical di	.: To	1 ☐ Yes 2 No  27. Manner of Death	1 Minpatient 2 LER	Outpatien  b. Time of	t 3 DOA	4 Nursing Hom	e 5 🗌 Residen Id. Describe how	ce 6 Other (Spec	fy)
ion	Attending F r death, ector: After by the funera	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury at Work? M 1 ☐ Yes	s 2 □ No		injury obcarroo	
Division	or Attendation of the control of the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office	28	f. Location (Stre City or Town,	et and Number or Rui	al Route Number,
ō	oepital or Atten hours after deat unerel Director: iy filled in by the			Sulfailing, Sto. (Specify)				Only of Tomin,		
	Hospital 24 hours 2 Funerel	edical	(Check only 2 Medical Examis	sician: To the best of my knowle ner: On the basis of examination	dge, death and/or inv	occurred at the time, overtigation, in my opinion	date and place, an	d due to the cau	ise(s) and manner as e and place, and due	stated.
	I 4 F 5	_		and manner stated.			-			0 1110 00030(3)
	24 24 H	Med	29b. Signature and title of certifier	()		29c. License nu	umber	290	d. Date signed /Month	O- V
	To the Hoe within 24 h To the Fun completely	Med	0/10/	COSI	pl	29c. License nu	umber 4566	290	d. Date signed (Month)	O- V
)	24 24 H	Med	29b. Signature and the o certifier  3. ame and address of person who co	impleted cause of death (Item 23		Print)	umber 4566	290	d. Date signed (Month	O- V
	24 24 H	Med	29b. Signature and the o certifier  3. ame and address of person who co	Co Si	ex	Print)	umber 45666	Bc 6	d. Date signed (Month	

DHMH 17 Rev 1/2001

Swint, Dorothy

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			Registrar AMFND#31, SOCI		,BMW,McCo (	Serincale of	Deam	2. Date of Deat	9. 110.	3. Time of Death
	Physici		Khodarahm	Shahryary				Nov. 8,	2004	8:21 P M
	/Medio		4a. Facility Name (If not institution, ga		r)	4b. City, Town, o	or Location of Deat	h	4c. County of	
			Suburban Hospi		11 - 11 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	Bethesda		O Data of Birth	Montgo	
l	Funeral Director		231-35-2440	Sex   7. A 1 2 M 2 □ F	79 Y	Months Davs			<sup>Year)</sup> 1925	9. Birthplace (State or Foreign Country) Iran
	and and		Usual Residence of Decedent  10a. State  10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Mary In a h	ţ	Virginia Fairf	ax	Vienna					1 □ Yes 2X No
	or 28s	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	nat Country?
	ath wil	rain	8702 Westwood Fo			22182			JSA	
36	be filed within 72 hours after death with the Maryland tial Hygiene. ad other than "natural", or itams 23a or 28a-f show event. It is Marylad Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1  Yes 2 If Yes, Give Year or Dates	s? <b>%</b> No	<ol> <li>Was Decedent of I If Yes, specify Cub</li> <li>Yes 2√x No</li> </ol>	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		- American Indian, White, etc. White
Maryland 21215-0036	2 hou	ted	15. Decedent's I	Education	16a. E	Decedent's Usual Occu	pation		6b. Kind of Busi	iness/Industry
215	thin 7:	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed)  College (1-4o		Give kind of work done life. DO NOT use retire	during most of wo d)	nking		
2	ygien ygien nar th	Son		5	Ge	neral	40 M-45 - 4- N-			Armed Forces
and	12 should be filed within h and Mental Hygiene. 7 Is marked othar than "traumatic event, If e Man	Be	17. Father's Name (First, Middle, Las Rashid Shahryary	,				<sup>me (First, Middle, M</sup> Farhadi	faiden Sumame,	)
7	hould d Mer marke	ို	19a. Informant's Name/Relationship		19b. l	Mailing Address (Street			City or Town. S	tate. Zio Code)
$\mathbf{Z}$	th an Ith an 27 Is I		Linda Shahryary/		1 100	ostolaciyan iyosta seri-vateri				
re,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a once.		20a. Method of Disposition	Ū	20b. Place of I	1202 Cranb i Disposition (Name of crematory or other pla	ce)	Date 2	20c. Location - C	ity or Town, State
E	Page Fir: =		1 ☑ Burial 2 ☐ Cremation 3 1 ☑ Donation 5 ☐ Other (Spec		9	x Memorial	· 1	11/04 E	airfax,	Virginia
Baltimore,	mit. spartm ports ny inju		21. Signature of Funeral Service Lic	ensee		22. Name and Addre	ess of Facility	RAL HOME, Vienna,	TNC.	
<u>-</u>	g Q E ≌ 9		Techail Otites	wife		·				
			23a. Part1. Enter the disease, of co shock, or heart failure. List on	mplications that caus ly one cause on each	ed the death. Do no line.	ot enter the mode of dyi	ng, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		TROK	0			2 days
	Examiner			Due to (or a	as a consequence of	):				
	1	je l	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequence of	f):				
	cuted	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events	С.						
0,	be executed iclan and burial-transit	EX	resulting in death) Last	Due to (or a	is a consequence of	f):				
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9	ding p	0	IF FEMALE:	23c. If yes, outcom	ne of pregnancy				and Date	of dollars.
P.O. Box	that the death certific ed by the attending p detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 ☐ Live birth	2 Fetal death at time of death	3 □Ectopic pregnanc 5 □ Other (specify) □	у		23d. Date Montl	*
Records, P	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions	contributing to death	but not resulting in	the underlying cause gr	ven in Part I.	23e. Did tob	_/	ute to the cause of death?  Probably 4 Unknown
900	law re as bee	Completed	1					24a. Was an		ere autopsy findings available or to completion of cause of
H.	The ate hi	E OC						perform	ledi? de	ath? ∃Yes 2⊟ No
Vital	cian: ertific actor,	Be (	25. Was case referred to medical examiner?	Manitot				ath (Check only one	9)	
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no	ding l h. After funer	tion	27. Manner of Ceath  1 Watural 5 Pending  2 Accident investigat	(Month, E		jury Wo	rk? ]Yes 2□No	200. Describe no	w injury occurred	
Division	or Attendation after deati	Certification:	2' Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	Injury - At home, farretc. (Specify)	m, street, factory, office		28f. Location (Str City or Town		or Rural Route Number,
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying I (Check only one)	Physician: To the bearing: On the basis and manner	of examination and	death occurred at the to	me, date and place opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manr te and place, an	ner as stated. d due to the cause(s)
	vithii To th	M	29b. Signature and title of certifier	1000		29c. Licen			d. Date signed (	(Month, Day, Year)
•			• Alle	000		84	25/8		vove	MUDER 7, WE
_	ID		30. Name and address of person wh	o completed cause o	f death (Item 23a) (1	Type, Print)	PILE	, H40	1 13	CO 2085
:	Sta	ate	31. Date filed (Month, Day, Year)	32. Pegi	strar's Signature	Look	NOV 1 2	2014 2	20maras	A done

DHMH 17 Rev 1/2001

SHAHRYARY, KHODARAJH

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Florence Walls Strong 01:15 AM November 12, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 217 Richard Drive Chestertown KEnt 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 84 Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) April 18,1920 9. Birthplace (State or Foreign **Funeral** Days 1□M 20XF 84 Yrs. Country 222-10-6494 Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show i Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23e or 28a-f show other traumatic event, it a Medical Examinar must be recitied at Director 1XYes 2 No MDKent Chestertown 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 217 Richard Drive 21620 USA Completed by Funeral permit. Peges 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Owner Hospitality 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edgar E. Walls, Sr. Evelyn Mae Dean 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jospeh Wilber Strong, Sr./Husband 217 Richard Dr., Chestertown, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Important: If eny injury o St. Paul's Cemetery \* 4 □Donation 5 □ Other (Specify) Nov.15,2004 Chestertown, MD 21. Signature of Funeral Service Licenses PDC9 Fellows, Helienbein & Newnam, P.A 130 Speer Road, Chestertown, MD 21620 23a. Pert1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Due to (or as a consequence of): resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the phy use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 Vio
9 Unknown ত্ Month Day Year P.O. I ed by the a detached f 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy certificate 1 Yes 2 or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only onle) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 1 Yes Medical Certification: To 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27 Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation М 1 Yes 2 No filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel D completely filled i To the Hospitel Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifig 29c. License numbe 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) Name and address of person who 31. Date filed (Mont trar's Signature State 1 5 2004 Registrar

1- State of Maryland / Department of Health and Mental Hygiene per fh G839 1-18-05: Las equilibria of Death 37848 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4, 2004 **Physician** November 10:45 AM Beatrice Muriel Scull /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chester River Manor Chestertown Kent | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | July 10, 1910 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 1 □ M 2 🗓 F 94 Yrs. Director Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ahow s 23a or 28e-f ahor 1X Yes 2 No MD Kent Chestertown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 221 Richard Drive USA Pages 1 and 2 should be filed within 72 hours after death Funera nontral, or itams? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced er than "netur. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Buyer Retail othert 7 is marked othe traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be and Mental Harry Hugh Hudson Carrie Melvin 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Pritchett/Nephew 1504 Dolorosa Ct., The Villages, Ladylake, FL Health tam 27 itam 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of the Important: If its any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Sudlersville Cemetery Nov.9, 2004 Sudlersville, MD <sup>22. Name and Address of Facility</sup>
Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer ROad, Chestertown, MD 21620 21. Signature of Puneral Service Licenses 23a. Part1. Enter the disease, or conshock, or heart failure. List only utons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death or complication only one of Stock Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Understand Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetel death in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | ed by the a detached f 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an as S autopsy certificate ha 25 No 1 ☐ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' 2 Other. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manney of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attending Injury 1 Natural s after decreased by the firm the firm 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hour. tha Funaral Dirac. 4 - Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as states.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 24 ho
To tha Fund
completely f (Check only one) of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a 10060301 who completed cause of death (Item 23a) (Type Print) PS STES CHESTENTOWN, MD 266 to C. KIMER, W) State Registrar

			1 - For State Registrar	State of Maryland		artment of He			giene Reg. N2 0 0 4	37849
		п	Decedent's Name (First, Middle, Last)	*				2. Date of Dea	ath	3. Time of Death
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	Examir		4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, or Lo	ocation of Death		4c. County of De	
			ANNE ARUNDEL MEI	DICAL CENTER	R	ANNAPOLI			ANNE AR	UNDEL
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday) Yrs.		Hours Min.	8. Date of Birt (Month, Day	v, Year)	irthplace (State or Foreign Country)
ŀ	Director		216-34-8198 Usual Residence of Decedent	72	115.			1/3/19	32 MA	RYLAND
	yland 10w		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mar.	tor	MD. WORCEST	ER	OCI	EAN PINES	3			1 X Yes 2 No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	23a	ral	101 HIGH SHERIFF	TRAIL		21811			USA	
	er de	nue		Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of Hispa Yes, specify Cuban,	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
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yla	shoutd the market umetic	٦	STEVEN	LUBARSKI			LOUI		OLINOWSKI	-
Maryland	and and reum		19a. Informant's Name/Relationship (Type,							Zip Code) 21403
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. item 27 ie marked other than "naturet", or iteme 23a or 28e-f show other treumetic event, the Medical Examinet must be notified.		SCOTT SAFFELL  20a. Method of Disposition			ARUNDEL sition (Name of	april (al.)	BAY R	D., ANNAP	OLIS, MD.
nor	t. Page dment c rtant: if njury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem	cem	netery, cren	natory or other place)  V CREMAT	TON 11	/13/04	CVKFCVTT	T.F MD
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9 xo	h certifica ending ph	dical	d.  IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregnancy	у		The	Lun	23d. Date of de	livery
Вох 6	s death certifica ne attending ph ed for use as th	dical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 170	If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat	y eath 3□	Ectopic pregnancy Other (specify)	The	Lun		livery Day Year
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State of Maryland / Department of Health and Mental Hygie ( ) 37850 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death o Physician Genevieve E. Snowden November 6, 2004 3:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign
 Country) **Funeral** Months 1 ☐ M 2 🕱 F Yrs. Director 112-26-7258 3-20-1926 Massachusetts Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show 7 is marked other than "neturel" or Items 23a or 28e-f shor treumatic event, the Macical Examiner out to mailbural Maryland Prince George's 1 DYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12329 Melling Lane 20715 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or hearth any injury or other treumatic event 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 years Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Duckworth Theresa Morahan ျ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine M. Flaherty/ Daughter 12329 Melling Ln., Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11-7-04 Kalas Crematory Edgewater, MD 4 □ Donation - 5 □ Other (Specify) 21. Signature of Fisheral enviced icensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe*e*r Onset and Death Immediate Cause (Final **Physician** cerebellar Stroke disease or condition resulting in death) > 2 day /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine rsician and e burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical phys the L as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 1☐Live birth 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, heart failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 27000 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 YNo Certification: To 27. Manner of Dath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No ☐ Accident after death the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funerel C completely filled ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatule and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 11-06-2004 MA address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Pkwy., Annapolis, MD 21401 Robert Peterson, M.D. 31. Date filed (Month, Day Year) 32. gistrar's Signature State 9 2004 Registrar

			1 - For State Registrar	State of N	Maryland /	Depa Cer	artment of I	Health a	and M	ental Hyg	ie <b>z</b> e 0 0	4	37851		
	Dhyoisi	an.	1. Decedent's Name (First, Middle, Las	t)						2. Date of Dear Month		Year	3. Time of Death		
	Physici /Medio		Bessie L. Sch							Novembe	r 6, 20	004	9:00 A M		
	Examin	er	4a. Facility Name (If not institution, give		•		4b. City, Town, Annap	of Death		4c. County of Death  Anne Arundel					
	Funeral		Heritage Harbour   5. Social Security Number   6. Se		Age (In yrs. last	birthday)	If Under 1 Year	If Under		8. Date of Birth					
	Director		218-40-1776	□M 2 <b>X</b> F	90	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day 4-11-19	14	9. Birthplace (State or Foreign Country) 14  9. Birthplace (State or Foreign Maryland			
	pug A		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	ocation						10d. Inside City Limits		
	f sho	ō	Maryland Anne Ar	undel		napo							1 ☐ Yes 2 🛣 No		
	r 28e-	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of V	What Co	untry?		
	th witi	alD	938 Tidewater Gr	ove Ct.			2140	1			τ	JSA			
	ems	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S.	13.	Was Decedent of	Hispanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		e - Amer	ncan Indian, a. etc.		
36	or It	by Fu	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date	<b>∑</b> No		1 □ Yes 2 <b>X</b> Xlo				Specify	,-	hite		
8	tiled within 72 hours after death with the Maryland Hygiene. uther than "neturel", or Items 23a or 28e-f show ant, the Madical Examiner must be notified at	ted t	15. Decedent's Ed	ucation		6a. Deced	dent's Usual Occu	pation			16b. Kind of Bu				
212	thin 7: e. an "n	Be Completed	(Specify only highest gra-	de completed) College (1-4d	or 5+)	(Give life.	kind of work done DO NOT use retire	during mos ed)	t of workir	ng					
2	ygien ygien rer th	Соп	12th			Hon	nemaker	Ī				ome			
and	I be fill he del he del he other	Be	17. Father's Name (First, Middle, Last)	V-11,,				18. Mothe		(First, Middle, I					
Ë	should nd Me mark imatic	ို	George L.  19a. Informant's Name/Relationship (7)		1	9b. Mailir	ng Address (Stree	t and Numbe					ip Code)		
<u>8</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "neturel", or Items 23a or 28e-f show any injury or other traumatic event, the Madical Examiner must be notified at Once.		Charles J. Schult												
ore,			20a. Method of Disposition	Domoval from Sta		of Dispo	osition (Name of matory or other pla	ice)	D	ate	20c. Location -	City or 7	Town, State		
Ĕ			1 ☐ Burial 2 🏹 Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	)	"   Kala		rematory		1-7-0		Edgewat				
Baltimore, Maryland 21215-0036	permit Depart Import any in		21. Signature of Juneral Service Licen	M			2. Name and Addr 273 Solon								
v	Pnysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	olications that cause one cause on each	sed the death. D	Oo not ent	er the mode of dy	ng, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death		
	/Medical Examiner		resulting in death)	Du V (or	as a consequenc	ce of):	1						13 900		
	- LXummer	er	Sequentially list conditions,	b. 17/26	reimen	5 6	Viscotic						4 4R		
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Penny	CINUS P	Frie	91100						742		
o î	be executed sician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or	as a consequence	ce of):	VI VI						0 /0-		
8760,	ate be executed hysician and ihe burial-transit	cal		d											
9	ertifica ling ph	Medi	IF FEMALE:	00- 11											
Вох	The law requires that the death certific tle has been signed by the attending p tage 2 should be detached for use as	Physician/M	in the past 12 months?		ne or pregnancy 2 □ Fetal dea t at time of death	ath 3[	Ectopic pregnand Other (specify)	:y			23d. Dat Mo		very Day Year		
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o. O.	res that the de signed by the a be detached f	by P	Part II. Other significant conditions of	entributing to death	n but not resulting	g in the u	nderlying cause gi	ven in Part I		23e. Did tob	acco use conti	ribute to	the cause of death?		
ğ	w require been sig should b	ted								1 □ Y€	s 2 No	3 Pro	bably 4 Unknown		
ec	law r nasbe e 2sh	Completed								24a. Was a autops	у Г	prior to co	opsy findings available ompletion of cause of		
Vital Records,	sician: The law s certificate has b lirector, page 2 s									perform		death?	2 No		
<u>=</u>	sician certif irector	o Be	25. Was case referred to medical examiner?	Hospital:		0.4.4	Ot	1,9424		(Check only on					
Division of	Attending Physician: r death. ector: After this certified by the funeral director, I	-	27. Manner of D ath	28a. Date of I	atient 2 ☐ ER/ njury 28t	b. Time of	II JUDOA	4 Nu		ne 5 🗆 Reside 8d. Describe ho			ify)		
0	ath. r: After se funer	atlo	1 Natural 5 Pending 2 Accident investigation		Day Year)	Injury		rk? ]Yes 2□	No						
<u>X</u>	i or Attendater death Director: I in by the	Certification;	3 Suicide 6 Could not be determined	286. Place of	Injury - At home, etc. (Specify)	, farm, str	eet, factory, office		2	8f. Location (St. City or Town		ar or Rui	ral Route Number,		
	oltal o urs af erel D														
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	sician: To the be iner: On the basis and manner	s of examination	dge, death and/or in	h occurred at the t vestigation, in my	ime, date an opinion, dea	d place, a th occurre	nd due to the ca d at the time, da	iuse(s) and ma ate and place, a	nner as :	stated. to the cause(s)		
	To the within To the comp	Me	29b. Signature and the of certifier	11111			_	se number		2:	9d. Date signed	i (Month	, Day, Year)		
			Many Les	MIL			D 00	1680	66		10/6,	104			
			30. Name and address of person who concludes J. Schul		-		Print)			2 C+	ling 17	7 21	065		
	Sta	te	31. Date filed (Month, Day, Year)	32. F 9i	strar's Signature	FIU	A LITE	T 17.	#20	Z, SLEI	TING V	A ZI	000		
	Registr	ar	NOV - 9 2	004	an B		beck								

State of Maryland / Department of Health and Mental Hygien 2004 37852 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 19, 2004 HELEN RITA SITES 5:58 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST VINCENT de PAUL NURSING CENTER FROSTBURG ALLEGANY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sep 15, 1924 Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Months Ŵ٧ Director 235-40-1460 80 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show or then "naturel", or Items 23a or 28a-f show the Wedical Evant servings be positived at MD Allegany 1 ☐ Yes 2 ☐ No Cresaptown Director 10e. Street and Number 10g. Citizen of What Country? 13139 Warrior Drive SW 21502 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filled within 72 hours after of Department of Health and Mental Hygiene Importent: If frem 27 is marked other then "naturel; or Iten eny injury or other treumatic event, the Medical Exempt Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cashier <u>Celanese Corp</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Frank Glencoe Mary Rose Glencoe 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia McCagh daughter P.O. Box 5174 Cresaptown MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 □Burial 2 □ Cremation 3 □ Removal from State 11/22/2004 LaVale Restlawn Memorial Gardens <sup>4</sup> □ Donation 5 □ Other (Specify) MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA Part. Their the disease, or complications that daused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Advunced Physician Dement disease or condition resulting in death) 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to mind a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consiguence of Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Penkinson's disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time-of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 Tes 2 No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Worsockshir 00055325 No V 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frostburg MD21532 MD 48 Tarn WONSOCK STITN Terrace 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 3 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 14 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** James Milton November 12, 2004 23:59 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Cheverly Prince Georges | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yee Sept. 8, 1 5. Social Security Number Sex 14⊡M 2□F 7. Age (In yrs. last birthday) **Funeral**  Birthplece (State or Foreign Country) Director 241-78-5687 55 Yrs. Sept. 1949 Lumberton, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "naturel", or Items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examinar must be notified at Director Maryland Prince Georges 1X Yes 2 No Capital Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 Topeka Ave. 20743 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton Thomas Theresa Guions 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is eny injury or other traignes. Michelle Thomas / Wife 419 Topeka Ave. Capital Heights, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery Nov. 18,2004 Suitland, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Alexander S. Pope Funeral Homes, P.A.
5538 Mariboro Pike/Forestville, Md. 20747 Charles Espoure M00981 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, of shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any leading to the cause. Enter Underlying Cause (Disease or injury Examiner anding physician and use as the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Wes decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery ed by the attended for us 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? certificate 2□ No 1□ Yes 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: ٩ 1 ☐ Yes 2 🕱 No 2 SR/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; 1 Natural To the reception 24 hours after death.

To the Funeral Director: After the funeral bird in by the fur 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and titte of certifier 29c. License number 29d. Date signed (Month, Day, Year) cralla 10 30. Name and address of person to completed cause of death (Item 23a) (Type, Print) tal Dive charely mo PIRISON 3001 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 1 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 2 MAHLON AMERICUS TAYLOR JR. 2004 12:46p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Burnie or I If Under 24 Hrs. North Arundel Hospital Glen
If Under 1 Year Anne Arundel 8. Date of Birth (Month, Day, Jan 27 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**⊠**M 2□F 73 Yrs วิ๊ 931 Director Maryland 218-24-6116 Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Directo 1 ☐ Yes 2 X No MD Kent Kennedyville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whaf Country? Items 23a or 27005 Lambs Meadow Farm 21645 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 25 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2X No White ģ Specify: permit. Pages 1 and 2 should be tiled within 72 hours Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural; any injury or other traumatic event. The Modical Exagnes. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mahlon A. Taylor, Sr. Ruby Leaverton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21645 Gladys E. Taylor (wife) 27005 Lambs Meadow Farm Kennedyville, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Still Pond Cem. 11/7/04 \* 4 ☐ Donation \* 5 ☐ Other (Specify) Still Pond, MD. nila 21. Signalure of Fundral Service Lic Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross St. Galena, MD. 21635 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. 23a. Part1. Enter the Approximate Interval Return Immediate Cause (Final disease or condition resulting in death) Onset and Death Priysician Myocardial Infarction /Medical Due to (or as a consequence of): **Examiner** Abdominal Aortic Aneurysm Sequentially list conditions, any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nunsequence or) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy to in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Prostate Cancer 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 XNo Hypertension 24a. Was an autopsy performed? 1 Yes Division of Vital Hypercholesterolemia 2 🕱 No To the Hospital or Attending Physician: Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Japital ...
4 hours after dea...
val Director: After 5 Pending 1.X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D50688 11/2/04 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Marshall Benjamin 301 Hospital Drive, Glen Burnie, MD. 21061 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 37855 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Alfred Earl Toefield III November 2004 1:20A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Silver Spring Holy Cross Hospital Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Months Days Hours 1X M 2□ F 37 Yrs. 448-70-5700 June 9, Director 1967 Wisconsin Usual Residence of Decedent the Maryland 10a, State 10c, City, Town or Location 10b. County 10d. fnside City Limits 7 is marked other than "natural", or Items 23e or 28e-f show treumatic event, the Medical Evantual natural be notified at 1X Yes 2 No MD Director Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 13007 5th Street 20720 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1X Yes 2 ☐ No filed within 72 hours after Hygiene. Wher than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: 186-192 Specify: Black À 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) 12 Coflege (1-4or 5+) Federal Government Police Officer permit. Pages 1 and 2 should be filed:
Department of Health and Mental Hygic
Importent: If item 27 is marked other t
any injury or other treumatic aven? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alfred Earl Toefield, Jr. Edna Joyce Clopton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl J. Toefield-Keen/ Sister 2911 Ivydale Street Wheaton, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Quantico National 11/12/2004 Quantico, Virginia <sup>1</sup> 4 □ Donation 5 □ Other (Specify) Cemetery
22. Name and Address of Facility
Robert E. Evans Funeral Home
Paris MD 20715 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pancytopenia /Medical Due to (or as a consequence of). **Examiner** Acquired Immune Dificiency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit requires that the death certificate be executed Septicemia Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical Acute Renal Failure as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 4☐Pregnant at time of death the detached 9 Unknown 9 Unknown ģ Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy 2X No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Xinpatient 2 ☐ ER/Outpatient 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: 1 X Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide within 24 hours a To the Funerel I 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check one) 29b. Signature and title of ce rt/fier 29c. License number 29d. Date signed (Month, Day, Year) D60619 11/9/04 IE LUNNIE who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd. Silver Spring Connie l'e 20910 31. Date filed (Month, Day, Year) 32. Raistrar's Signature State Registrar

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Dir	ector		227-07-9895 Usual Residence of Decedent		87	115.					July 1	5, 1	917	Vi	ginia	1
land	A 1	_ }	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation	-			<u></u>				Od. Inside	City Limits
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21215-0036 ad within 72 hours after death with the Maryland (giene.	o oner man natural, or tems 23s or 28sr snow event, the Medical Examiner must be notified at	ed b	3X Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:		16a. Dece			tion			16b K		WII		
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. e e	thed f	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊡Pregnant at 9⊡ Unknown	t time of d	eath 5□	] Other (s	pecify)					1410		Duy	1001
I Records, P.O. Box 6 The law requires that the death certific	detached f	Ę	Part II. Other significant conditions con	tributing to death b	ut not res	ultina in the ur	nderlvina	cause give	n in Part I.		23e. Did 1	obacco i	use conti	ribute to th	e cause of	death?
Vital Records, ician: The law requires t	ا هر	d by	- FARKII	VSOTVS	5 4	17750	CA	50	-		1 🗆		No		ably 4 [	
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lo f	eral	Ë	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time of		28c. Injury Work			28d. Describe				/	
VISION VITE IN GRATH.	. e T	atlo	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monal, Da	y rour,	Injury	М		es 2⊡ñ	No						
Division of I or Attending Physical death.	by ti	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At ho	ome, farm, str	et, facto	y, office		2	28f. Location ( City or To			er or Rura	Route Nur	nber,
Urs af	i bed															
Division of Vita To the Hospital or Attending Physician: within 24 hours after death.	completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Phys (Checklonly one) 2 Medical Examin	ier: On the basis o	t examına	wledge, death tion and/or inv	occurred restigation	at the time n, in my opi	e, date and inion, deat	d place, a th occurre	ind due to the ed at the time,	cause(s) date and	) and ma d place, a	nner as st and due to	ated. the cause(	s)
thin 2	eldmo	Med	29b. Signature and title of certifier	and manner sta	ated.		29	c. License	number			29d Dat	te signer	(Month.)	Day, Year)	
F 3 F	8		No dao	9 MM			1	7215	731		1	Nm	0)	8 9/	711	
2	5	ĺ	30. Name and address of person who co	mpleted cause of d	leath (Itom	23a) (Tune	Print?	70	1			-00	7	100	04	7
			19414 C	LEITERS	BU	RG	Pla	E Sh	ahab	16,6	95/01	UN	i. M	(1) E	174	12,
	Stat	e	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture	1	11	1 0 mg		. , 5, 0, 0	1	1 -110	1.		, ,
R	egistra	ar	NUV 13 2004	130		1	HICO.	11	1V 1	2 20	NA Z	2495	مراستي	2	Policy	Bedge

			1 - State of Maryland / Dep	partment of Health and Mertificate of Death	lental Hygiei Rag.	2004	37857
I	Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> Anna Marie Walker		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		2004 4c. County of Death	2:00P M
	Examir	ier	7409 Lanham Lane	Fort Washington	1	Prince Ge	orge's
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthda)		8. Date of Birth (Month, Day, Ye		lace (State or Foreign
	Director		217 38 1994 1 M 2 T 63 Yrs.	Months Days Hours Mill.	Feb 3, 19	941 Mary	'land
	and and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or 1	ocation		1	0d. Inside City Limits
	Mary fied	to	Maryland Prince George's Fort	Washington			1 ☐ Yes 2 ☐ No
	or 288	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	1111
	23a c		7409 Lanham Lane	20744	Į	United Sta	ites
	er des	Funeral	Armed Forces?	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	rs aft	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ Nyo If Yes, Give  3 □ Widowed 4 ☑ ☑ vorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify:	• •
ğ	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural" or Items 23a or 28a-f show event. Its Medical Ever it ar must be rotified at	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b.	Kind of Business/Inc	ite dustry
2	ithin 7 19.	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of worki DO NOT use retired)	ng		
7	ygien ygien yer th			maker		Own Home	
Maryland 21215-0036	ntal H ed otl	Be	17. Father's Name (First, Middle, Last) Michael Ignatius Hartmann, Sr.		(First, Middle, Maid		
2	should nd Me mark matic	10		ing Address (Street and Number or Rura	rie Amreir		Code
S	nd 2 ; alth ar 27 is rrtrau			9 Lanham Lane, For			
altimore,	es 1 a of Hea fitem r othe		20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition	osition (Name of Ematory or other place)	Date 20c.	Location - City or To	wn, State
Ĕ	Page ment ant: It ury o		1 ☐ Burial XXCremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)  Lee Cre			inton, Ma	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event. The Medical Exercitant must be notified at 2008.		21. Signatur of Funeral Service Lifensee	22. Name and Address of Facility Lee	Funeral H	Iome,Inc	6633 01d
	40280		23a-Part. Enter the disease, or complications that caused the death. Do not en	Alexandria Ferry		n, MD 2073	
г	<b>n</b>		shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  In per Lensive Car  Due to (or as a consequence of):	diovascular Diseas	e		
	Examiner		Chronic Obstruct	ive Pulmonary Disea	ase		
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C.  Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dicalE	4				
9	tificate ng phy as the	Ф	0.				
Box	death certific e attending p id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delive	,
	at the dea by the at tached fo	/slcl		Other (specify)		Month	Day Year
٥.	that the	Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
Records,	98	d by		,			ably 4 Dunknown
<u>0</u>	sw requir s been si should l	olete	-		24a. Was an	24b. Were autor	isy findings available
	The law cate has page 2 s	Completed			autopsy performed? 1 ☐ Yes 2 ☑ 📉	prior to con death?	pletion of cause of
Vital	i <b>clan</b> : Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	26. Place of Death		103	20.10
oto	Physic this or	2	1 ☐ Yes 2 🛣 🔏 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		ne SCHesidence		)
u	ding P h. After funer	tlon	27. Manner of Death 1 XXatural 5 □ Pending (Month, Day Year)   1 Injury 2 □ Accident investigation   28a. Date of Injury (Month, Day Year)   28b. Time (Month, Day Year)   28b. Time (Month, Day Year)   28b. Time (Month, Day Year)   28b. Time (Month, Day Year)   28b. Time (Month, Day Year)   28b. Time (Month)   28b. Time (Mon	of 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred	
Division	or Attend after death Director: , d in by the f	flca	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, s		28f. Location (Street a	and Number or Rural	Route Number.
á	al or A s after al Direct	Certification:	4 ☐ Homicide determined building, etc. (Specify)	,	City or Town, Sta	ite)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director.	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal call Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the cause and at the time, date a	s) and manner as stand place, and due to	ited. the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	29c. License number		ate signed (Month, L	
_			Victor E. Herry my	D20986	N	ov 15, 200	)4
1	p n		30. Name and address of person who completed cause of death (Item 23a) (Type				
	D		31 Date filed (Month Day Vear) 32 Parietrar's Signature	ataway Road, Clinto	on, MD 207	35	
-	Sta Registr		NOV 1 5 2004	port			

State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 2ď84 Nettie W. Wilkinson 9:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Mar. 22, 1914 9. Birthplace (State or Foreign **Funeral** 1□M 2√F 90 Yrs. 578-44-4543 Mar. Georgia Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f show Examinar must be rectified at 1 Yes 2 No Maryland Prince George's Beltsville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5403 Cordwall Place 20705 United States death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White etcan filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 ☐ Divorced American "natural" Completed The Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ith and Mental F 27 is marked of traumatic ever Pages 1 and 2 should be Ned Wiggs Emma Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 la y or other tran Wesley L. Branch - Friend 5403 Cordwall Pl., Beltsville, MD 20705 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem. 11/17/2004 Suitland, MD permit. 21. Signal re of Funeral Service Licenspe 22. Name and Address of Facility Stewart Funeral Home lway onn 4001 Benning Rd., N.E. Wash., DC Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate dause (Final **Physician** Coronary Artery Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner <u>Hypertensive</u> Heart Disease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner anding physicien and use as the burial-transit The law requires that the death certificate be executed H perlipidemia resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ò Month Day Year 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown Altered Mental Status 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has autopsy performed? 1 Yes 2 No rector. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ₹ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo Certification: To ō 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pellij within 24 hours a ertifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) MD25464 30. Name and ordress of person who complete cause of death (Item 23a) (Type, Print) Jean Linzau, M.D. 6323 Georgia Ave., N.W. #318, Wash., DC 31. Date filed (Month, Day, Year) 3. Registrar's Signature State 1 5 2004

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Maryla	and / Depa	artment of H	lealth a Death	nd Mental H	lygiena Reg. No	2004	37859
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date ofMonth	Death		3. Time of Death
	/Media	cal	Margaret L. Ward					Novem			
	Examir	ier	4a. Facility Name (If not institution, give s 21009 Brook Kno11			4b. City, Town, or Laytons		Death		. County of De Montgon	
	Funeral		5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year	If Under 2	4 Hrs. 8. Date of			irthplace (State or Foreign
	Director		208 <b>-</b> 16 <b>-</b> 6215	M 2 🔀 F	80 Yrs.	Months Days	Hours	4 Hrs. 8. Date of (Month, May 1	1, 19	24 P	Country) ennsylvania
	pue *		Usual Residence of Decedent  10a. State 10b. County	10e	City, Town or Lo	cation			-		10d. Inside City Limits
	Manyli	ō			Silver S						1 ☐ Yes 2 ☒ No
	r 28a-	Director	Maryland Montgomes  10e. Street and Number	. y	oliver 2	10f. Zip Code			10g. Cit	tizen of What (	Country?
	th with	al D	11602 Connecticut	Avenue		20902				SA	
	ema erm	Funeral	11. Marital Status	Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	ispanic Orig	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - An Black, Wh	nerican Indian,
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:	,		Specify: Wh	
8	2 hour	ed t	15. Decedent's Educ		16a, Dece	dent's Usual Occupa	ation		16b. K	ind of Busines	s/Industry
215	hin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most	of working			
2	ed wit	Con	12		Sa1	esperson				rniture	•
Maryland 21215-0036	be tile	Be	17. Father's Name (First, Middle, Last)	rro.1.1.o				's Name (First, Midd		Sumame)	
<u> </u>	hould d Mer marke	2	Francis Thomas La  19a. Informant's Name/Relationship (Type		10h Mailir	Address (Street		garet Blar or Rural Route Num		Taura Class	Tin On day
<u>8</u>	ad 2 s Ith an 27 is i		Patricia Ethridge	*				Road, Lay			
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hyglene. Department of Health 27 is marked other than "natural", or itema 23a or 28a-f show amyorinant: If item 27 is marked other than "natural", or itema 23a or 28a-f show amy injury or other traumatic evant, the Modical Exemples must be notified at once.		20a. Method of Disposition		D. Place of Dispo		e) _   3T	Date	20c. Lo	ocation - City o	or Town, State
E	Page		1 Burial 2 Cremation 3 Re 1 Donation 5 Other (Specify)	emoval from State		on <sup>n</sup> Nation etery	al   W	ovember 24 2004	Arl	ington,	Virginia
Salt	epartr epartr nports ny inju		21. Signa de of Funeral Service License	P	Fi	Name and Address	ss of Facility	ns Funera	al Hor	ne Inc.	
m_	205 g g		Notient 10 ()	hi						r Sprin	g, MD 20901
Г			23a. Party. Enter the disease, or complice shock, or heart failure. List only on	eations that caused the de e cause on each line.	eath. Do not ent	er the mode of dying	g, such as c	ardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Myelodyspla		ndrome					Months
	Examiner			Due to (or as a cons	equence of):						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):						
	nd ransii	Examiner	triat ittiliated events								
50,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a cons	equence of):						
	cate phy:	dlcal	d								
X	death certific e attending p id tor use as	√Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of preg						23d. Date of de	alivery
. Box	0 0	Physician/M	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time o		Ectopic pregnancy Other (specify)			.	Month	Day Year
л О	at the de by the a tached	hys	9 🗆 Unknown	9□ Unknown							
ś	The law requires that the te has been signed by the vage 2 should be detached.	by F	Part II. Other significant conditions con	inbuting to death but not r	esulting in the ur	nderlying cause give	en in Part I.	1	_		to the cause of death?
oro	w requir been si should I	eted						- 11	」Yes 24		Probably 4 []Unknown
Records,	The law cate has b page 2 s	Completed			-			24a. Wa	as an lopsy rformed?	24b. Were a prior to death?	utopsy findings available completion of cause of
		e Co	25. Was case referred to medical					1 ☐ Yes	2 X No		s 2 No
Vital	Physician: rthis certitic ral director,	OB	examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA Othe		of Death <i>Check onl</i> sing Home 5 ☐ Re		E V Othor (So	ecify) Daughter's
סר	g Physi ter this o	T:U	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work	at	28d. Describ			Residence
201	ending I sath. or: After he tuner	atlo	1 X Natural 5 Pending 2 Accident investigation	(WONIII, Day 10al)	injury		res 2 □ No	0			
Division	or Attendater death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre	eet, factory, office			(Street an own, State		Rural Route Number,
_	pital		29a. Certifier 1X Certifying Phys	inima. Ta sha bans af an il			- 4-4 4				
	24 hc 24 hc e Fun etely	edical	(Check only one) 2 Medical Examin	ician: To the best of my k er: On the basis of exami and manner stated.	ination and/or inv	estigation, in my op	e, date and pinion, death	occurred at the time	e cause(s) e, date and	and manner a place, and du	s stated. e to the cause(s)
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the tuner	Me	29b. Signature and title of certifier			29c. License			29d. Dat	e signed (Mon	th, Day, Year)
)			I (hihi by	Janok		D424	452		Nov	vember	4, 2004
	10		30. Name and address of person wing cor				D:	1120=	7	WE CC	220
			Chitra Rajagopal, 31. Date filed (Month, Day, Year)	M.D. 1811		e Pnilip	Drive	, #327, 0	ıney,	MD 208	332
	Sta Registr		NOV 1 2 2004	52. Hegistrar's sig	B	Sports	,				

State of Maryland / Department of Health and Mental Hygiene 37860 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year John Wade 12:45 AM November 9,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles 3813 Mt. Pleasant Road Waldorf If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 X M 2 □ F Months 578-20-0946 Director 86 December 27,1917 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "naturel", or items 23a or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits Maryland Charles 1XYes 2 No Waldorf Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20601 USA 3813 Mt. Pleasant Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Yes 2 VNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1☐Yes 2☐No Specify: ð Specify: Black XXWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. District Government Elementary/Secondary (0-12) College (1-4or 5+) Tax Assessor 12 permit. Pages 1 and 2 should be fift Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Wade Mary Elizabeth Sewell ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Friend / Daughter 4033 Green's Way Circle Collegeville, PA 19426 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State \* 4 Donation 5 Other (Specify) Peters Ch Cem 11/15/04 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Odessa MO1323 Adams Funeral Home P.A. Aquasco, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 Physician ૪ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the first index of the cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 1 Tes 25 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home sidence 6 Other (Specify) 1 Yes 2 No ٩ 2 ☐ EB/Outpatient 3□ DOA this After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. De sales how injury occurred Certification: 1. Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation М after death Director: / J in by the f 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who-completed cause of death (Item 23a) (Type, Print) >0 0 31. Date filed (Month, Day, istrar's Signature 32. R State NOV 1 2 2004 POPLER Registrar

State of Maryland / Department of Health and Mental Hygier 🔎 🕦 👢 37861 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 10 **Physician** MINNIE MARIE WADE NOVEMBER 2004 9:00 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death LORIEN FRANKFORD NURSING &REHAB. CTR BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 28, 1954 Birthplace (State or Foreign Country) **Funeral** Days 1□M 2X F 212-62-7017 Director 50 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show traumatic event, the Medical Examiner must be notified at Aberdeen 1 ☐ Yes 2 No Directo Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 350 Old Post Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23a any injury or other traumatic event, the Medical Event APT MADE. 21001 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 □Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No δ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Walter Lieske, Sr. Nola Lorretta Pierce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Glen Wade, Sr./husband 350 Old Post Road, Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) St. James United Cem. 11/12/04 Havre de Grace, MD 22. Name and Address of Facility Lisa Scott Funeral Home, P.A. 21. Signature of Funeral Service Licensee 552 Lewis Street, Havre de Grace, MD Approxima 078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Sepsis 480 /Medical Due to (or as a consequence of): **Examiner** Truct In Ecchion Uninary Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? Month Day Year 4□Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown signed by Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vegetative 5 Like 1 🗆 Yes 3 Probably 4 Unknown peen Diabeles 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 1 Inpatient 2 EN/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \( \text{Homicide} \) within 24 hours after To the Funerel Dire Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29b. Signature and title on certifier 29c. License number 29d. Date signed (Month, Day, Year) 4 D43386 11.11.04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12. 1714 Echw Place, Bullinore, un 21217 to ward 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 2 2004 Registrar

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п	Director		217-50-2974 3924	1 <b>X</b> M 2□ F	57	Yrs.	Months Days	Hours		(Month, Day, Y an. 22,	1947	Mar	place (State or a otry) yLand	roreign
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	with Be or	ă	Avenue P. Bu	ilding 147			10f. Zip Code 219	02		10g	. Citizen of W	hat Cour	itry?	
	death ms 2	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13.1			in? (Specify	Yes or No-	USA 14. Race	- Americ	an Indian.	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "naturel", or items 23e or 28e-f show other treumetic event, the Medical Examinat must be notified at	þ	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 X Yes 2 1  If Yes, Give Year or Dates:	No		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🎇 No	n, Mexican, Specify:	Puerto Rica	an, etc.)	Black	, White, Bla	etc.	
5-0	72 ho natur	eted	15. Decedent's E (Specify only highest gi	ducation	168	a. Dece	dent's Usual Occupa	ation	of working	16	b. Kind of Bu	siness/Ind	dustry	
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yla	Meni Meni Marke Metic	၉	unknown					Cora	Wyche	3				
Maryland	12 sho h and 7 is ma rreum		19a. Informant's Name/Relationship  Ultra N. Wyche				g Address (Street a							
	1 and Healt em 2		20a. Method of Disposition	/ daughter			<ul> <li>Preside</li> <li>sition (Name of</li> </ul>	nt St	., Sui		, Balt:		<u> </u>	1202
Baltimore,	Pages nent of ant: If it		1 ☐ Burial 2 X Cremation 3 [ '4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemete	ery, cren	natory or other place is & Co.	·			st Ches	•		
Balt	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree	1	21. Signature of Funeral Service Lice	nsee			Lisa Sco 552 Lewi	s of Facility	neral	Home, I	P.A.			
8760,	Physician /Medical Examiner bulksician and provided and ithe prival-Itansit in prival	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	TTC ADF a consequence a consequence a consequence	of):	QUAMOUS C	ARCING	AMO			U	Onset and De	
Box 6	ath certiff attending for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death		Ectopic pregnancy Other (specify)				23d. Date Mont		ry Day Yea	ar
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Division	iel or Attend s after death al Director: , ad in by the f	Certification:	3 Suicide 6 Could not be determined		ry - At home, fa :. (Specify)	arm, stre	et, factory, office		28f. L	ocation (Street City or Town, St	and Number ate)	or Rural	Route Number	τ,
	To the Hospitel or within 24 hours after within 27 the Funerel Dire completely filled in Direct Completely filled	edical (	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best of miner: On the basis of and manner sta	examination an	e, death	occurred at the time estigation, in my opi	e, date and printed inion, death	place, and d occurred at	lue to the cause the time, date :	e(s) and manr and place, an	ner as sta d due to	ited. the cause(s)	
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	118		30. Name and address of person who		,		Print)						1 -7	
	Sta	te	GEORGE L. HENRY, 31. Date filed (Month, Day, Year)	32. Registra	IARYLANI r's Signature	) HE	ALTHCARE	SYSTE	M, PEF	RRY POI	VT, MD	219	902	
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DH	MH 17 Rev 1/20	001												

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 37863 For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 13 1:35PM 2004 Hazel A. Webb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 400 Academy Street Hurlock Dorchester If Under 24 Hrs.
Hours Min.

8. Date of Birth (Month, Day, Year)

April 17, If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 K 86 TN Director 218-32-3322 Usual Residence of Deceden the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Dorchester Directo Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with USA "natural", or Items 23a 400 Academy Street 21643 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Marned Maryland 21215-0036 1 Yes 2 No White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic avent, the Mechapone. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maynard B. Jenkins Etta Elizabeth Snuder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 382, Rising Sun, MD Disposition (Name of Date 2) Jack Fritts/son 21911 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rising Sun. MD Brookview Cemetery 11-16-2004 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Licensee Queen Street, Rising Sun. MD 21911 uenand Enter the disease, or complication. hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cares on each line. Approximate Interval Between Onset and Death Part 1 c, or heart failure. List only one ca Immedia\* Cause (Final diseas r condition resulting in death) Physician /Medical Due to for as a consequence of): **Examiner** titi Sequentially list conditions, if any, leading to immediate ease. Enter the deriving Cause (Disease or injury that initiated events resulting in death) Last Du- to (or s a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed **burial-transit** and Due to (or as a consequence of): attending physician P.O. Box 68760 by Physician/Medical as the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2) ET No 1 Tyes 2 No 1 Yes Division of Vital director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 5 Pending investigation Matural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) pus who completed cause of death (Item 23a) (Type, Print) 1.0. 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar

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	Funeral Director		<ol> <li>Social Security Number</li> <li>215-26-9852</li> </ol>	6. Se	M 2√2 F	73	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of B Month, D Feb 26	3, Year	331	Country) MD	State or Foreign
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)	, , , , , ,		> /		/V				D5	5084	4			1/22/	2004	
	0		30. Name and address of	1 /	completed cause of	death (Ite								7	•	
	Sta	te	Jose Lover 31. Date filed (Month, Day	a/M/[	32. Regis		ature		4		nberl	and MD	21:	502		
	Registi		NOV	3 0 2	004 3	neva	- E	de	O Car A	1						

		1 - Stete Registrar	ate of Marylan	d / Depa	artment of H	lealth and N Death	Mental Hygie	2004	37865
		Decedent's Name (First, Middle, Last)			imouto or i	Journ	Reg. 2. Date of Death		3. Time of Death
Physic /Medi		Bertram O. Wilkerson					Month NOV 1	Day Year	+ 9:55 PM
Exami	ner	4a. Facility Name (If not institution, give street 19800 Tranquility Cir	,	so l	4b. City, Town, or Hagersto	Location of Death		4c. County of Dea Washingt	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
Director		219-03-9836 <sup>1</sup> X <sup>M 2</sup>	OF	85 Yrs.	Months Days	Hours Min.	March 30,19	ai/ L	ouintry) 1D
/land		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
e Man ta-fsh illind	ctor	MD Washington	Hag	erstow	n				1 No 2 No
with th	Director	10e. Street and Number			10f. Zip Code			Citizen of What Co	ountry?
death v	Funeral	19800 Tranquility Cit	rcle Apt.2		Vas Decedent of Hi	Spanic Origin? (Sp.	ecity Yes or No-	A 14. Race - Ame	erican Indian
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Modical Examinar cust be notified at once.	by Fun	1 Never Married 2 Married 1	med Forces? □Yes 2 XNo ∕es, Give ar or Dates:	l I	Yes, specify Cubar  ☐ Yes 2 X No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
5-0036 72 hours af	ted	15. Decedent's Education (Specify only highest grade comp		16a. Deced	ent's Usual Occupa	ation	16b	. Kind of Business	
21215 ad within 7 giene. er than "r i. in wa	Completed	Elementary/Secondary (0-12) Co	llege (1-4or 5+)	1	kind of work done d OO NOT use retired;		1		
d 20 Hilled v Hygie other t	e Co	17. Father's Name (First, Middle, Last)		Ordna	nce Techn		Dej e (First, Middle, Maid	ot. of th	ie Navy
Maryland d 2 should be file th and Mental Hy 7 Is marked oth traumatic evant	To B	George B. Wilkerson					lice Wheel		
Alary 2 sho 1 and h 1s me	ľ	19a. Informant's Name/Relationship (Type, Pri	·				al Route Number, Cit		
e, N 1 and Health am 27		Betty D. Beeler/Daugh 20a. Method of Disposition		14507	Heavenly	Acres R	idge Hanco	ock, MD 21 Location - City or	
altimore, mit. Pages 1 ar partment of Hea portant: If itam y injury or othe		1 XBurial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	ar iroin State		sition (Name of latery or other place	1			
alti mit. I spartm poorta y injui		21. 5 rature of Funeral S rvice Lic- see	V. 10111	on Cem	Name and Address	11/19 s of Facility		Connellsb West Main	- 1.00
<b>o</b> 89 E 2 9		Hickory	MAR	Gr	ove Funer	al Home,	P.A. Hand		
76 -		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final	s that caused the death se on each line.	Do not ente	r the mode of dying	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
Pnysician /Medical		disease or condition resulting in death)	Oue to (or as a consequ	Jence of):	le k	idera	ma		39 months
Examiner		Sequentially list conditions.							
M de di	niner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a nonsecu	usinge of):					
icate be executed physician and sthe burial-transit	Examiner	that initiated events c.	Due to (or as a consequ	uence of):					
8760, cate be ex chysician the burial	edical	d.							
		IF FEMALE:							
Geath certific death certific e attending p	Physiclan/M	in the past 12 months?	es, outcome of pregna ]Live birth 2 []Fetal ]Pregnant at time of de	death 3□	Ectopic pregnancy Other (specify)			23d. Date of del	ivery Day Year
at the de	hysi		Unknown						
IS, F	by	Part II. Other significant conditions contributing	ng to death but not resu	ılting in the un	derlying cause give	n in Part I.		5/	the cause of death?
ecords, law requires t as been signe	eted						1 Tes		obably 4 Dunknown
<b>*</b> • • •	Completed						24a. Was an autopsy performed	prior to death?	stopsy findings available completion of cause of
	Be C	25. Was case referred to medical				26. Place of Death		lo 1∐Yes	2 □ No
Of V Physic rthis ce	၉	examiner? 1 Yes 2 No Hospita	1   Inpatient 2   1	ER/Outpatient	3☐ DOA Other	. 4 Nursing Hor	me 5 esidence		pify)
ding F ding F After funer	tlon	1 Natural 5 ☐ Pending	. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work? M 1 □ Y	at ? es 2 □ No	28d. D <i>e</i> scribe how in	ury occurred	
UIVISION I or Attanding after death. Diractor: Afte	Certification:	2 Could not be	Place of Injury - At ho	me, farm, stre			28f. Location (Street	and Number or Ru	Iral Route Number,
Ital or irs afte rat Dir led in	Cert		building, etc. (Specify				City or Town, Sta		
To the Hospital or Attanding Physician: Within 24 hours after death. To the Funaral Director: After this certifical completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)  1 Certifying Physician: 2 Medical Examiner: Or an	To the best of my known the basis of examinated manner stated.	vledg <i>e</i> , death ion and/or inv	occurred at the time estigation, in my opi	e, date and place, a inion, death occurre	and due to the cause ed at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier	1		29c. License	number	29d. D	ate signed (Month	n, Day, Year)
		Mud Ha	when	m, M	D 7	04647	3.	11/18/	2004
2/		30. Name and address of person who complete	d cause of death (Item	23a) (Type, P	rint)	11 17	Haar	ne into	מוליות מותו
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat	to 1	0.011	1.	.; Hago	IMBI CO	4111) 01170
·Registr	ar	NOV 3 0 2004	Deniva	B	sport				

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State of Maryland / Department of Health and Mental Hygien	0	0	4
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			1 - For State Registrar		Maryland	d / Depa <i>Cei</i>	artment of tificate o	Health a	and Me		ien <b>2</b> () () (	371	866
	Physici /Medi	cal	1. Decedent's Name (First, Middle James H. Young	Jr.				-	N	Date of Deat Month ovember	Day Ye	ar 04 1:45	of Death
	Examir Funeral	ner	4a. Fecility Name (If not institution 7734 Washington 5. Social Security Number	Blvd.	Age (In yrs. Ia	st birthdav)	4b. City, Town Elkridg  If Under 1 Year	;e		. Date of Birth	Howard		e or Foreign
	Director		578-58-5183 Usuel Residence of Decedent	1 DM 2 □ E	59	Yrs.	Months Day	s Hours		Date of Birth (Month, Day, ug. 8,		Birthplace (State Country) Shingto	n, DC
	he Maryla 28a-f show	ector	MD Howar	d 	E1kr	Town or Lo							City Limits 9s 2 □ No
	be filed within 72 hours after death with the Maryland lat Hyglene. d other than "natural", or Iteme 23e or 28e-f ahow avant, the Medical Examiner must be notilised at	Funeral Director	10e. Street and Number 7734 Washington 11. Marital Status	12. Was Deced	ent Ever in U.S		10f. Zip Code 20710  Vas Decedent o	Hispanic Ori	igin? (Specif	v Yes or No-		mencan Indian,	
9000	hours after tural', or Ite al Examine	d by Fu	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	□No		Yes, specify Cu	o Specify:			Specify: B	Iack	
21215	d within 72 giene. er than "nai i'ha Medic	Completed by	15. Deceden (Specify only higher Elementary/Secondary (0-12) 12th		or 5+)	(Give life. L	ent's Usual Occ kind of work dor DO NOT use reti uftsman	e during mos	t of working		16b. Kind of Busine Private	ss/Industry	
Maryland 21215-0036	0 E E S	To Be C	17. Father's Name (First, Middle, James H. Young	Sr.				Eve1	yn Ty	ler	faiden Sumame)		
	1 and 2 Health a em 27 lu ther tra		19a. Informant's Name/Relations Venant Young/W  20a. Method of Disposition		20b. Pla	7734		ton B1		lkridge	City or Town, State MD 207 20c. Location - City	10	
Battimore,	permit. Pages Department of Important: If It any injury or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	210	erdale	Park C	rem. N	ov.12	,2004 F	Riverdale Tenkins F	, MD	Home
n	8.0 E 18.0		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death.	71	6 Kenne	dy St.	NW Wa	ashingt	on, DC 20		ate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	JTE as a conseque	LEUKI	EMIA					Onset and	
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	as a conseque	ence of):							
8/60,	ate be executed hysician and the burial-transit	dical Exa	resulting in death) Last	Due to (or	as a conseque	ince of):							
.O. BOX 6	death certific e attending p id for use as	Physiclan/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		2 ☐ Fetel d tat time of dea	leath 3 🗌	Ectopic pregnan Other (specify)	су			23d. Date of c	delivery Day	Year
cords, P	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant condition	ns contributing to deat	h but not resulti	ing in the un	derlying cause g	iven in Part I.		_	acco use contribute		
He He	The ate ha	Completed								24a. Was an autopsy perform	ed? prior to	autopsy findings to completion of ? es 2 \( \square\) No	s available cause of
OI VIE	Physician: The Ir this certificate har all director, page	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 □ Inp		P/Outpatient	JU DON	ther: 4 🗆 Nur		heck only one 5  Resider	) nce 6 ⊡Other <i>(Sp</i>	pecify)	
USION	ttending l death. stor: After the funer	Certification;	27. Manner of Death  1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could r	ation of be	Day Year)	8b. Time of Injury	į.	ork? ]Yes 2 □ N	No		v injury occurred	Bural Boute Nu	wher
5	spital or one after or one all Direct of filled in the control of		29a. Certifier 1 ☑ Certifyin	building,	etc. (Specify)	edge, death	occurred at the	me date and	1 place, and	City or Town,	State)	as stated	
	To the Hospital or Attenwithin 24 hours after dealt To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical I one)  29b. Signature and title of certifier	xaminer: On the basis and manner	s of examination	n and/or invi	estigation, in my 29c. Liger	opinion, deat	h occurred a	it the time, dat	d. Date signed (Mo	ue to the cause(	s)
0		1	30. Name and address of person v			?3a) (Type, P	rint) 62	417	15 EEEN	BELT	11-15	- D4	
	Sta Registra	-	31. Date filed (Month, Day, Year)  NOV 1 5 2	3€ Regi	Strar's Signatur	re /		1666	FAR	CK HI	2076		
DHI	H 17 Bev 1/20		MA I 2 C	TOUR TOUR	e K	1900							

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene (	14 3786
Certificate of Death	, 0,00

			T = For State Registrar	Otate of Wi	aryland / L	Cer	tificate of I	Death	a wichtar r	Reg.		31001
	Division		1. Decedent's Name (First, Middle	a, Last)	-				2. Date of Month		Day Year	3. Time of Death
	Physici /Medio		FLORENCE J	EANNE YIA	NNAKIS	,			NOVE			4 8:04p M
	Examir	er	4a. Facility Name (If not institution				4b. City, Town, or	r Location of D	Death		4c. County of Dea	ith
			Chestertown 1		Rehab ge (In yrs. last bir	thda)	Cheste			Righ	Kent	the less /State or Fornian
	Funeral Director		5. Social Security Number  160-24-8480  Usual Residence of Decedent	1 M 2XF		Yrs.	Months Days			Day, Ye	ar) L C	thplace (State or Foreign ountry) aryland
	land ow		10a. State 10b. County		10c. City, Tow	n or Loc	ation					10d. Inside City Limits
	Mary If sh	ţō	MD Ken	t	Bett	ert	on					1XX Yes 2 ☐ No
	or 28g	irec	10e. Street and Number				10f. Zip Code			10g.	Citizen of What C	ountry?
	23e (23e (1811)	al	308 Ericsson	n Ave.			21610				S.A.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show appringury or other traumatic event. Its Madical Examinar must be multiled at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces  îed 1 □ Yes 2 ▼ If Yes, Give Year or Dates:	?		/as Decedent of H Yes, specify Cuba ☐ Yes 2 <mark>]</mark> € No		? (Specify Yes or luerto Rican, etc.)	No-	14. Race - Am Black, Whi	
2-0	72 ho	eted	15. Decedent (Specify only highes	t's Education	16a.	Deced	ent's Usual Occupa	ation during most of	working	16b	. Kind of Business	/Industry
2	ithin nen "	nple	Elementary/Secondary (0-12)	College (1-4or	5+)		and of work done of ONOT use retired					
2	fygler fygler her th	õ	12 17. Father's Name (First, Middle, I	l act)		Se	cretary		Name (First, Mid		1 Compa	any
Maryland	ntal Hed of	Be	William Erne		. Sr.				E. Mod		ien <i>Sumame)</i>	
Ž	houtch Me	၉	19a. Informant's Name/Relationsh			Mailine	Address (Street a				ty or Town, State,	Zin Code)
<u>8</u>	th an		Ed Yiannakis								ertown,	
ē,	s 1 ar f Hea item 3		20a. Method of Disposition		20b. Place of	Dispos	ition (Name of atory or other place	1	Date		Location - City or	
E O	Pages ment of I ant: If ite		1 XBurial 2 ☐ Cremation  1 4 ☐ Donation 5 ☐ Other (Si			-	nd Cem		1/8/04	S	till Po	nd, MD.
Baltimore,	permit. I Departm Importal any injui		21. Signalure 15 ner LS rvice	Licensia	100510	Ga.	Name and Address Lena Fu	s of Facility neral	Home o	of S		L. Schaec
			23a. Part1. Enter the disease, or	complications that cause	d the death. Do r						ia, MD.	Approximate Interval Between
4	Physician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	-a. Par		tic	Cun	(QV	_			Onset and Death
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	of):						
	cuted	Examiner	that initiated events	c								
68760,	rificate be executed ng physician and as the burial-transit	Medical Ex	resulting in death) Last	Due to (or as	a consequence	of):						
h.4	artifica ing ph B as th	Med	IF FEMALE:									
P.O. Box	The faw requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death		Ectopic pregnancy Other (specify)			_	23d. Date of de Month	livery Ɗay Year
	ires that the de signed by the a d be detached f	by	Part II. Other significant condition	ns contributing to death t	out not resulting in	the un	derlying cause give	en in Part I.				the cause of death?
Vital Records,	w require been si should t	Completed								fas an	24h Were at	itonsy findings available
Ř	The taw ate has page 2 s	du							— au	itopsy erformed	death?	utopsy findings available completion of cause of
g	(G LT	e Co	25. Was case referred to medical					OC Dines of	1 ☐ Ye. Death (Check on		No 1 ☐ Yes	2 <b>Z</b> No
	yaician: is certific director,	To Be	examiner?	Hospital:	ent 2 ER/Ou	tnatient	3□ DOA Othe	Nn /			6 ☐Other (Spe	city)
Division of	ding Phy th, After this funeral o		27. Mann f Death  1 atural 5 Pending 2 Accident investig	28a. Date of Inju (Month, Da		Fime of njury	28c. Injury Work				njury occurred	o.iy,
Divisi	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could redetermi	not be ined 28e. Place of In building, et	jury - At home, fa c. (Specify)	rm, stre	et, factory, office			n (Street Town, Sti		ural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C		g Physician: To the best Examiner: On the basts of and marmer st	f examination and							
	To th within To th	Me	29b. Signature and title of certifier	1	-		29c. License	number		29d. (	Date signed (Mont	h, Day, Year)
			* AINIA	//			DOC	5882	24		11-4-04	
			30. Name and address of person	who completed cause of o	death (Item 23a) (	Type, P						
			Paul Donahe	er, M.D.	119 C 1	Vor	th Main	St.	Galena,	MD	. 21635	5
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 0.		rar's Signature	14	books					

			For State Registrar	State o	of Marylan	d / Depa <i>Cer</i>	artment of H tificate of L	ealth and M Death	fental Hyg	giene20	04	37868
	Physici /Medic		Decedent's Name (First, Middle Margaret		R.		Adams		2. Date of Dea Month 11 2	Day	Year 4	3. Time of Death 2:46p M
	Examir		4a. Facility Name (If not institution	*	mber)			Location of Death		4c. County		
	**		125 Balnew Av	7enue 6. Sex	7. Age (In yrs.	last hirthday)	Tur	ner Stati	8. Date of Birth	Balt:		
	Funeral Director		062-14-3858	1□ M 2√F	85	Yrs.	Months Days	Hours Min.	9-8-19	, Year)	Coun	lace (State or Foreign try)
	D		Usual Residence of Decedent	1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					9-0-19			Md.
	show	_	Md. Bal	timore	10c. Cit	y, Town or Lo					1	0d. Inside City Limits  X☐ Yes 2☐ No
	he Mi	ecto		ciliore		Turne	r Station	1				
	with the cort	Funeral Director	10e. Street and Number 125 Balnew Ave	e.			10f. Zip Code 21222		1	10g. Citizen of W USA	hat Coun	try?
	death ms 23	era	11, Marital Status	12. Was Dec	edent Ever in U		Vas Decedent of Hi	spanic Origin? (Spe	ecity Yes or No-	14. Race		an Indian,
21215-0036	be filed within 72 hours after death with the Maryland lat Hygiene. dother than "natural", or itams 23c or 28a-1 show avant, I've Medical Evantian matter trust be troillied at	b	1 ☐ Never Married 2 ☐ Mai 3 ☑ Widowed 4 ☐ Divorce	If Yes Gi	2 <b>X</b> No ve	ì	f Yes, specify Cubar □ Yes 2½ No	n, Mexican, Puerto Specify:	Rican, etc.)		Blac	
5-0	72 ho natur	Completed	15. Deceder	nt's Education est grade completed)		16a. Deced	lent's Usual Occupa	ation Juring most of worki	ina	16b. Kind of Bus	siness/Ind	dustry
21	han han	mple	Elementary/Secondary (0-12)		1-4or 5+)	life. L	kind of work done d OO NOT use retired;	)				
	filed within Hygiene. Ither than		12th grade  17. Father's Name (First, Middle,	l act)		Se	lf-Employ	'ed 18. Mother's Name	(First Middle	Liquor	Store	e Owner
Maryland	d 2 should be fil h and Mental H 7 is markad otl traumatic avan	To Be	Irvin	and ty	А	dams		Emma	(i ii st, iviladio, i	Smi		
ary	s 1 and 2 should f Health and Men itam 27 is marks othar traumatic	1-	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailin	g Address (Street a	and Number or Rura	al Route Number	r, City or Town, S	State, Zip	Code)
	ss 1 and 2 of Health a itam 27 is r othar tra		Michael Adams	Neph	ıew	2	17 Oak Av	e., Pikes	sville,	Md. 2	1208	
altimore,			20a. Method of Disposition  1 Burial 2 Cremation 4 Donation 5 Other (		State 20b. F	Place of Disposemetery, crem rbutus	sition (Name of natory or other place Mem. Pk.	11-27	_	20c. Location - ( Arbutus		
Balt	permit. Page Department of Important: If any injury or gotte.		21. Signature of Funeral Service	Licensee .		22	Name and Addres	•	Ba. 1101 I	ltimore, E. North	Md. Ave	21202
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that	caused the deat	Do not ente	the mode of dying	g, such as cardiac c	or respiratory arm	est,		Approximate Interval Between
4	Pnysician		Immediate Cause (Final disease or condition		ronary	secure an	disease					Onset and Death
	/Medical Examiner		resulting in death)		(or as a conseq		ans cus c					119
	, 4	_	Sequentially list conditions,	b. Due to	labetes lor as a conseq	Mellit	us					Dily
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<								
Ć,	execunate and and all-tra	Exar	that initiated events resulting in death) Last	c. Due to	as a conseq	uence of):					-	>11y
8760,	cate be executed physician and the burial-transit	dlcal		d.	Hiperch	olester	olemia					>114
9	tificat ng phy as th	led			J							
O. Box	at the death certifit by the attending I tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live I	tcome of pregna birth 2 Peta nant at time of d lown	I death 3	Ectopic pregnancy Other (specify)			23d. Date Mon		ry Day Year
<b>Q</b> _	s that	by Ph	Part II. Other significant conditi	ons contributing to a	leath but not res	ulting in the un	iderlying cause give	n in Part I.	23e. Did tot	bacco use contri	bute to th	e cause of death?
rds	w requires been sign should be								1 □ Ye	es 2 🗷 No	3 🗌 Proba	abiy 4 Unknown
Records,	e la has	Completed							24a. Was a autops perform	ned? de	ere autorior to consath?	sy findings available apletion of cause of
Vital		BeC	25. Was case referred to medical examiner?	al				26. Place of Death				20.10
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 🔀 No	-	Inpatient 2 🗆			r: 4 Nursing Hor				)
	ing After une	on:	27. Manner of Death 1,⊠Natural 5 ☐ Pendi	iig .	of Injury hth, Day Year)	28b. Time of Injury	28c. Injury Work	?	28d. Describe ho	ow injury occurre	d	
Division	or Attanding affer death. Diractor: After d in by the fune	icat	3 Suicide 6 Could		of Injuny - At he	ome farm eter	M 1 ☐ Y	res 2□No	28f Location /St	reet and Number	r or Pura	Paula Number
Di	in Dir	Certification;	4 Homicide determ	build	ing, etc. (Specify	y)	et, factory, office	6	City or Town	7, State)	or Hurar	Hodie Namber,
	To the Hospital or within 24 hours after To the Funeral Direct completely filled in 1	edical C	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physicien: To the Examiner: On the b and man	e best of my kno pasis of examina iner stated.	wledge, death tion and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	and due to the ca ed at the time, da	ause(s) and man ate and place, ar	ner as stand due to	ated. the cause(s)
	To th within To th comp	Me	29b. Signature and title of certific	er O			29c. License	number	2:	9d. Date signed	(Month, L	Day, Year)
١,	1		Smela	Ouganz	MD		D 2	3085		Nov 23	, 20	4
5	1		30. Name and address of person PAMELA OU		se of death (Item			A LTIMORE	, MD :	21224		
0	Sta		31. Date filed (Month, Day, Year		Registrar's Signa		/					
	Registr	ar	DEC 0	1 2004	Genera	13	Spark	21				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** BRANHAM, CHARLES **EDWARD** 2:15 A. M JR. 11 27 - 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **AVENUE** SHELDON BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours X1X M 2 □ F 214-54-4219 54 Director Yrs. 05-31-1950 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2**X** No BALTIMORE REISTERSTOWN MD. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 ERIN WAY 21136 U. S. A. filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√XNo BLACK Specify: XX Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) e kind of work done di DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) MARS SUPER MARKET LIFT FORK DRIVER 12 YEARS Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumattic event 2002. Be CHARLES BRANHAM, ARTINA VIOLIA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. BRANHAM (BROTHER) 4347 SHELDON AVENUE, BALTIMORE, MARYLAND, 21206 EDWARD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2XXCremation 3 Removal from State
4 Donation 5 Other (Specify) HILLTOP SERVICE CORP 12-01-2004 TOWSON, MARYLAND, 21204 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician mo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ⊞Unknown 1 ☐ Yes 2 ☐ No peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate 1 Yes 1 🗌 Yes 2 No XXNo To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 XX ther (Specify) BROTHER'S 1 ☐ Yes 2XXNo 1 🔲 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: after death. Director: After RESIDENCE 1XNatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number NOVEMBER 30,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FLAVIO KRUTER M D., 32 CROSS ROADS, OWINGS MILLS, MARYLAND, 31. Date filed (Month Pay 32. Registrar's Signature State Jacks Registrar

			1 - For State Registrar	State of N	Marylan	nd / Depa <i>Ce</i> a	artment of H	lealth a Death	and Me	ental Hyg	gien <b>9</b>	004	37870
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	Physicia /Medic		GERALDINE BURT	CON						Month NOV EUG.	Day	Year	9:14 AM
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	Funeral		5. Social Security Number	6. Sex 7. A		last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	B. Date of Birt (Month, Day	h		place (State or Foreign intry)
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0000	rat',	1 by	3	If Yes, Give ** Year or Dates	:		1 ☐ Yes 2X No	Specify:			S	ipecify: Wh	nite
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	artme artme ortan injury		' 4 ☐ Donation 5 ☐ Other (S <sub>k</sub> 21. Signature of Funeral Service	A	Met	ropolita	n Cremator	y I	11/27	/2004	Alex	andria,	, Virginia
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	Physician		shock, or heart failure. List Immediate Cause (Final	only one cause on each	IIIIe.								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or a		Ulas	twinle	SIIV	911	HELL	mou	are	HOUSS.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** 2004 Vettie Brown 10:05PM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Future Care-Sandtown Baltimore NA 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Yeer, Birthplece (State or Foreign Country) Days 216-12-7466 Director 94 11-20-10 Md. Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Haatth and Mental Hygiene. Important: if flem 27 is marked other than "natural, or items 23e or 28e-f show any finjury or other traumatic event, the Medical Examinating the notified at angles. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits NA Baltimore 1 XYes 2 □ No **Funeral Director** Md. 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA 441 Watty Ct. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ρ Black 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Other People Homes Unkn 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jefferson Maggie Brown John Wesley 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Theresa Penn Daughter 1628 Bruce Ct., Baltimore, Md. 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 12-2-04 Baltimore, Md. Greenmount Cem. 4 Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 la warre March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **Physician** Onset and Death /Medical Immediate Ceuse (Final disease or condition resulting in death) netastes: Squamons Carcinoma Examiner Examiner requires that the deeth certificate be executed ettending physicien end if for use es the burlal-transit nan av ter Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 1200 tension Due to (or as a consequence of) in su Hiciena non signed by the el Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was en autopsy performed? After this certificate has funerel director, pege 2 of 1 Tes 2 No 1 ☐ Yes 2 ☐ No the funerel director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) 28e. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Natural 5 Pending 2□ Accident investigetion 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours at To the Funeral Di complataly filled i 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. edical 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 060141 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) N EUtaw Ith Bald, mull 32. Registrar's Signature Threes 31. Date filed (Month, Day, Year) DEC 0 1 2004 State

DHMH 16 Rev 6/95

Registrar

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			1 _ State		partment of Health and	, ,	C C 1	07070
			Registrer  1. Decedent's Name (First, Middle, Last)	Ce	ertificate of Death	2. Date of Deat	eg. NZ 004	3   8   2
	Physicia /Medic		MERLE L. BLACKWELL	, SR.		NOV.	24, 2004	1102 A
	Examin		4a. Fecility Name (If not institution, give street and nut		4b. City, Town, or Location of Dea		4c. County of Dea	
			STELLA MARIS @ MERC		BALTIMORE		N/A	
	Funeral Director		5. Social Security Number  408-60-9107  Usual Residence of Decedent	7. Age (In yrs. last birthda)  Yrs.	/) If Under 1 Year If Under 24 Hrs Months Days Hours Min		'38 TEN	thplace (State or Foreign ountry) INESSEE
	yland		10a. State 10b. County	10c. City, Town or I	Location			10d. Inside City Limits
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	fter d r tterr	Fun	11. Marital Status 12. Was Dece Armed Fo 1 ☐ Never Married 2 ☐ Married 1 ☑ Yes	rces?	. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer	specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	
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	µ∤\ Sta	to.	David Riseberg 30 31. Date filed (Month Pay, Year) 2001 32. Ry	DI ST Paul gistrar's Signature	Pl Baltimore	md.	21202	

			1- State of Maryland / Dep	partment of Health and Nertificate of Death	lental Hygie	2004	37873
			Decedent's Name (First, Middle, Last)	Timeate of Death	Reg. 2. Date of Death	. No.	3. Time of Death
П	Physici		GRAVES HOLTON CRABTREE		Month November	Day Year	
	/Medio Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	November	4c. County of Dea	
			3515 56th Street	Cheverly		Prince Ge	eorge's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth		nthplace (State or Foreign ountry)
I.	Director		242-46-1705		April 26,	1935 No	rth Carolina
	land ow		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary Figh	tor	Maryland Prince George's Cheverly	J			1 ☐ Yes 2 X No
	h the	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What C	ountry?
	th wil	aiD	3515 56th Street	20784	U	.S.A.	
	r dea	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	s afte	by Fi	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:	,		
Ş	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show the Mudical Ever in er mat be notified a	ed b		edent's Usual Occupation	161	b. Kind of Business	nite
712	72 nic	piet	(Specify only highest grade completed) (Giv	e kind of work done during most of worki DO NOT use retired)	ng	D. KING OF BUSINESS	vindustry
21	d with	Completed	11 Mecha	anic	Co	oin Opera	ted Laundry
p	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai		
Maryland 21215-0036	Men Men Marka Marka	70	William Bruce Crabtree		e Elizabe		
Nar	12 sh h and 7 le m traum			ling Address (Street and Number or Rura			
	1 and Healt em 2		20a Method of Disposition 20b. Place of Disp	5 56th Street, Chev		ryland 20 c. Location - City or	
nor	ages ant of t: If it		1 ☐ Burial 2 XCremation 3 ☐ Removal from State cemetery, cre	ematory or other place)	200		
Baltimore,	perrit. Pages 1 and 2 should ba filad within 72 hours after death with the Marylan Depirtment of Health and Mental Hygiene Importent: If item 27 le markad other then "naturel; or items 23e or 28e-f show any njury or other traumatic event, the Mudical Evertinating the notified an once.		THECTOPOLIC	an Crematory   11/29 22. Name and Address of Facility Gas	9/2004 A	lexandria	Virginia
m	Depilion			739 Baltimore Ave.			
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Bilateral Pneumon:	i a			Onset and Death
Ш	/Medical		resulting in death)  a. Due to (or as a consequence of):	La			Days
н	Examiner		Sequentially list conditions, b. Parkinsons Disease	2			Years
	ed sit	Examiner	if ally, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	and al-trar	xan	that initiated events resulting in death) Last C.  Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dicai E	d				
9	tificat ng phy as th	0					
Вох	death certific attending pl	Physician/M	IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of de	livery
0	that the death hed by the atter detachad for i	sici		Other (specify)		Month	Day Year
<u>α</u>	hat the od by detacl	Phy	Part II. Other significant conditions contributing to death but not resulting in the	underhing eques ques in Part I	22a Did tehan		the cause of death?
ds,	signed of be defined	d by	Chronic Obstuctive Pulmonary Disease		1 🗆 Yes		robably 4 🖫 Unknown
200	w requir been s should	lete		s, hypercention	24a. Was an		
Re	he lav e has	ompleted			autopsy	prior to	utopsy findings available completion of cause of
Division of Vital Records,	ysicien: The is certificate hadirector, page	CO	25. Was case referred to medical	26. Place of Death	(Check only one)	No 1 ☐ Yes	2 No
>	ysici nis cen direc	To B	examiner? 1 ☐ Yes 2 ▼ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	O44	ne 5 <b>X</b> Residence	e 6 □Other (Spe	cify)
0 _	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 1njury		28d. Describe how i		
sio	tendi leath tor: / the fi	cati	2 Accident investigation	M 1 Yes 2 No			
Ξ	or Ai	Certification:	determined determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	treet, factory, office	281. Location (Street City or Town, St		ural Route Number,
_	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	al C	29a. Certifier 1X Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place.	and due to the cause	e/s) and manner	stated
	1 24 h	edicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurre	ed at the time, date	and place, and due	to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Mont	h, Day, Year)
	0 11	2	Jaward M. Cilles W	D0026607	No	ovember 2	9, 2004
	11/0	/	30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)			
			Edward T. Cullen, MD 4333 Old Branc  31. Date filed (Month, Day, Year)  22. Registrar's Signature	ch Avenue, Marlow H	eights, M	Maryland	20748
	Sta Registr	100	31. Date filed (Month, Day, Year) DEC 0 1 2004	Sparks			

Craig Hall Croxton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-07464 State of Maryland / Department of Health and Mental Hygiene, MAN 1- State Registrar AMEND TTEM #20b &c PER FH C838 tificate photograph 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month November 20, 2004 **Physician** 0155 A 914 /Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Piney Orchard Pkwy at New Waudh Chapel Road Odentan Anne Arundel 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign Country) If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Months Hours M 2□ F 206-70-3886 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28e-f show other treumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director enTo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō Items 23e +more 4 86 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2√ No 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: al by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "naturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "I any injury or other treumatic event, the Mestan injury or other treumatic event, the Mestan injury or other treumatic event, the Mestan injury or other treumatic event, the Mestan injury or other treumatic event, the Mestan injury or other treumatic event, the Mestan injury or other treumatic event, the Mestan injury or other treumatic event, the Mestan injury or other treumatic events. Elementary/Secondary (0-12) College (1-4or 5+) TUIDENT 18. Mether's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Telds OXTON xa.4 mela ta ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Na e/Relationship (Type, Print) 8618 the Sucamore 11/27/04 20a. Method of Disposition HICOMOTORICALLY CERETERY Rurial 2 Cremation 3 Removal from State ▲ Denation 5 ☐ Other (Specify) 21. Signature of Fund Service License No 2120 WSERTY \*W 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 47 disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 99 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 CUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \[ \subseteq \text{No} \] 24a. Was an certificate has autopsy performed Yes 2□No Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 1 XYes 2 No 3 DOA 5 Residence 6 NOther (Specify) At scene 1 Inpatient 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 2 d. Describe how injury occurred After 1 Natural 5 Pending investigation which 2 No 1 Tyes death. 2 Accident 4120104 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Process Without Public 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide May Ways Cane Noble 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Manual Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s). 29a. Certifier (Chec and manner stated. To the within 2 29d, Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier O.C.M.E November 20, 2004 ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp dus DAO ME 111 Penn Street, Baltimore, Maryland 21201 32 Registrar's Signature Date filed (Month, Day, Year) State Registrar DEC 0 1 2004

			For State Registrar		Maryland /	Depa Cei	artment o	f Healt of Dea	h and M ath		Reg. No.	04	37875
	Physici	an	1. Decedent's Name (First, Midd:	le, Last)		,	Crowell			2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic	al	Isaiah  4a. Facility Name (If not institutio	a give atmot and aumit	norl		4b. City, Tow	n or Locati	ion of Doath	11		004 ty of Death	6:55am <sup>™</sup>
	Examin	ięr		_			, ·	timor					
NO.	Funeral		Future Care N. 5. Social Security Number	6. Sex 7.	es St. Age (In yrs. last i	birthday)	If Under 1 Ye	ar If Un	nder 24 Hrs.	8. Date of Birt (Month, Da		9. Birth	place (State or Foreign
	Director		220-30-6869	1 🛣 M 2 🗆 F	68	Yrs.	Months Da	ys Hou	Jrs Min.	8-18		Cou	S.C.
	and w		Usual Residence of Decedent  10a. State 10b. County	,	10c. City, To	own or Lo	eation						10d. Inside City Limits
	f sho	ō	Md.	NA			imore						1 <b>X</b> Yes 2 □ No
	death with the Maryland ms 23c or 28a-f show f.must.be notified at	Director	10e. Street and Number				10f. Zip Cod	le			10g. Citizen o	f What Cou	ntry?
	th with	alD	2021 E. Eager	Street			2	1205			U	SA	
	ems ems	Funeral	11. Marital Status		ent Ever in U.S. es?	13.	Was Decedent	of Hispanic	c Origin? (Sp	ecify Yes or No- Rican, etc.)	- 14. R	ace - Ameri ack, White,	
9	hours after tural; or Ite al Evamina	ру Fu	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☑ Divorced	If Yes Give			1 □ Yes 2 🗖				Spec	ify: [	JSA
2-00-c	n 72 hours after death with the Marylan "natural", or Items 23c or 28a-f show edical Examinar must be notified at	ed t	15. Deceder	nt's Education		Sa. Dece	dent's Usual Oc	cupation			16b. Kind of	Business/Ir	idustry
<u>ე</u>	hin 72 an "nat	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed)  College (1-4	lor 5+)	(Give life.	kind of work do DO NOT use re	ne during i tired)	most of work	ing			,
7	filed within Hygiene. thar than "	Com	9th grade			Disa	abled				NA		
yland	d tal	Be	17. Father's Name (First, Middle,							e (First, Middle,		ame)	
_	should be ind Mental s markad umatic av	2	Johnnie  19a, Informant's Name/Relation:		3. Crov	-	na Addross /Str		Annie	B al Route Numbe		Format	
<u> </u>	C1 to 20 12		John Crowell				-			Baltimo			1213
	s 1 and 2 should f Health and Mer itam 27 is marks othar traumatic		20a. Method of Disposition				sition (Name or natory or other			Date	20c. Location		own, State
e E	Pages ent of nt: If i		1 Burial 2 Cremation 4 Donation 5 Other (				mel Cer		11-2	9-04	Dunda.	lk, Mo	i.
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other t 20029.		21. Signature of Funeral Service	Licensee		22	2. Name and Ad	dress of F	acility	Ba	ltimore	, Md.	21202
מ	90 1 2 8		& lady	wan	دع	8	March	F.H.	East		E. Nor		
8/60,	Physician /Medical Examiner and the prival transit	dical Examiner	shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	r as a consequence	ce of):	Stage	De.	ment	Ú,			Interval Batween Onseyand Death
O. Box 6	The taw requires that the death certificate be executed to has been signed by the attending physicien and oate 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live bir	ome of pregnancy h 2  Fetal dea nt at time of death n		Ectopic pregna Other (specify	,				ate of deliv	ery Day Year
ecords, P	w requires that been signed be should be det	by	Part II. Other significant condit	ions contributing to deal with the deal was a superior of the contribution of the cont	th but not resulting	g in the u	nderlying cause	given in P	art I.	23e. Did to	_ /		he cause of death?
r	The law re cate has bee page 2 sho	Completed	Mic	betes								prior to co death?	ppsy findings available impletion of cause of
Vital		BeC	25. Was case referred to medica	al				26. P	Place of Deat	h (Check only o			22,10
010	Physic this ce al direc	ToE	examiner? 1 ☐ Yes 2 ☑ No		patient 2 ER/	Outpatier		Other: 4	Nursing Ho	me 5 🗆 Resid	dence 6 🗆 O	ther (Specia	(y)
	ding P. h. After t funera		27. Manner of Death 1 ■ Natural 5 ■ Pendi		Injury 28t Day Year)	o. Time o Injury		njury at Work?		28d. Describe h	now injury occi	ırred	
<u> </u>	death. ctor: A the fu	cat	3 Suicide 6 □ Could		f Injury - At home,	farm et		1 ☐ Yes 2		28f Location /5	Street and Nur	nher or Run	al Route Number,
DIVISION	after of Dirac	Certification;	4 ☐ Homicide deter		, etc. (Specify)	, (4111, 31)	eet, raciory, on	100		City or Tox		150, 0, , (6)	2
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral director,	edical C	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ing Physician: To the b I Examiner: On the bas and manne	is of examination	dge, deat and/or in	h occurred at th vestigation, in n	e time, dat ny opinion,	te and place, death occur	and due to the red at the time,	cause(s) and r date and place	nanner as s , and due t	itated. o the cause(s)
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of pertifi	er				ense numb			29d. Date sign		
,		/		1	40			1)2	756	9	(1)	24/0	4
/	11		30. Name and address of person	who completed cause	+10	a) (Type,	Print) /8	38	Gre	eral	Tree	R	1 21208
8.	Sta Reg <u>i</u> st		31. Date filed (Month, Day, Year		gistrar's Signature	B	Soon						

		For State Registrar	State o	f Marylan		rtment of H tificate of L		d Mental Hy	giene Reg. No.	004	378	76
Physici		Decedent's Name (First, Middle, La Marilyn	st)		C	arroll		2. Date of Do Month	Day	2004	3. Time of C	PM
/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, or ROSED	44		4c. Cc	ounty of Death		•
Funeral Director		5. Social Security Number 6. S 213-62-8031		7. Age (In yrs. 1		If Under 1 Year Months Days		Min. (Month, D.	rth ay, Ye <i>ar)</i> -4–54	9. Birthp Coun	lace (State or latry)  Md.	Foreign
e Maryland sa-f show	ctor	Usual Residence of Decedent  10a. State  10b. County  Md.  Na	Ą	10c. City	y, Town or Lo Balt	cation imore					0d. Inside City	
with the	Dire	10e. Street and Number 360 Shagbark Ro	nad			10f. Zip Code 21220	)		10g. Citizer	of What Cour	itry?	
ges 1 and 2 should be filed within 72 hours after death with the Maryland in of Health and Mental Hygiene.  If it alm 27 is marked other than "natural", or itams 23a or 28a-f show or other than "natural", or itams 21a or 28a-f show or other traumatic event, to Manical Examiner must be notified.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced		2 No	1		spanic Origin	? (Specify Yes or No Puerto Rican, etc.)	0- 14.	Race - Americ Black, White, pecify: B1		
within 72 hours at iene. then "natural", or it o Maulcal Example.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1	-4or 5+)	(Give life. I	lent's Usual Occupa kind of work done o OO NOT use retired	luring most of )			of Business/Ind	•	
ld be filed w lental Hygie kad othar ti ic evant, th	To Be Col	12th grade  17. Father's Name (First, Middle, Last  Eugene		ap, Sr.	Tr	ansportat	18. Mother's	ept. Name <i>(First, Middle</i> Rebecca		Ltimore mame) Dori	-	
1 and 2 should be 1 Health and Mental I tam 27 Is markad o		19a. Informant's Name/Relationship	Type, Print)	usband			and Number o	Baltimore,	-			
permit. Pages 1 an Coparment of Heali It portant: If itam 2 any injury or other		20a. Method of Disposition 1 Durial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Special Content of the Content o	Removal from	State	emetery, cren	sition (Name of natory or other place I FOREST \		Date 11-30-04		ion-City or To gs Mill		
permit. Copariti		21. Signature of Funeral Service Lice	nsee , W	ane		. Name and Addres				e, Md.	21202	
certificate be executed /Medical Examiner /Medical Examiner /Medical and /Medical reasity for the purial-transity of the purial-transity	dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause juisease or injury that initiated events resulting in death) Last	b. 05 Due to	or as a consequence of the conse	vence of):	is biTi					Onset and Da	iatri
death certif e attending ed for use a:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live b	come of pregna irth 2 ☐ Feta ant at time of do own	Ideath 3□	Ectopic pregnancy Other (specify)			230	. Date of delive Month	ry Day Ye	ar
w requires that the debeen signed by the a		Part II. Other significant conditions  Hx DV T, PE	contributing to d	eath but not res	ulting in the u	nderlying cause give	n in Part I.		tobacco use Yes 2 🗷 N	contribute to th		
The law ate has b	Completed by		order erior		nicaT	ing An	=. U RV .			4b. Were autoprior to condeath?	npletion of cau	railable ise of
Attanding Physician: The redath.  actor: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation	Hospital: 1 X 28a. Date (Mon		ER/Outpatien 28b. Time of Injury	t 3 DOA Othe	26. Place of er: 4 ☐ Nursi	Death (Check only ng Home 5 Res 28d. Describe	idence 6		')	
	Il Certification:	3 Suicide 6 Could not lead to the determined of	build			eet, factory, office	e date and a		wn, State)	d manner as st		<i>∍r</i> ,
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical		miner: On the b		tion and/or in		number	occurred at the time,	date and pla		the cause(s) Day, Year)	
61		30. Name and address of person who		e of death (Item	23a) (Type	Print)		VE , BALTI				,
Sta Registr		31. Date filed (Month, Day, Year)	32. F	egistrar's Signa		Some	25 . 3 L. 3					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 4

Certificate of Death

			1 - For State Registrar	State of Maryland / D	Department of Health and Certificate of Death	Mental Hygie Reg.		37877
	Physici	an	Decedent's Name (First, Middle, Last	0 . 1		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deat		4c. County of Death	1727M
	Funeral Director		5. Social Security Number 6, Se 28-16-3884 15	THE ADE L	hday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth T(Month, Day Ye	9. Birth 1914 V	place (State or Foreign
	ryland how	,	10a. State 10b. County	10c. City, Town	or Location	,		10d. Inside City Limits
	the Ma	ecto	Maryland N/A	Ba	10f. Zip Code	100	Citizen of Miles A Co.	1 Yes 2 □ No
	h with	al Dir	351 Marya	dell Rd.	21229	10g.	Citizen of What Cou	1 1
ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other treumatic event, the Medical Evandor must be notified at once.	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1  Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ameni Black, White,	
-003	hours ntural',	ed by	3 Widowed 4 □ Divorced  15. Decedent's Edu	Year or Dates:	Decedent's Usual Occupation	166	Specify: B	ack
21215-0036	within 72 ene. then "nat	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed)  College (1-4or 5+)	(Give kind of work done during most of wo life. DO NOT use retired)	rking		-1 (1
d 21	filed w Hygier other th		17. Father's Name (First, Middle, Last)		18. Mother's Nar	me (First, Middle, Maid		is4 Electric
Maryland	should be ind Mental marked c	To Be	Ned Cray	ton	Fanni	ie Mae	2 Bry	die
Mar	nd 2 sho lith and 27 is m r treum	ij	19a. Informant's Name/Relationship (7)	po, Print g. ter) 19b.	Mailing Address (Street and Number or Ru	PA Number, Cit	ty or Town, State Zip	2/12/29
ore,	of Hea of Hea fitem		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F	- aamataa	Disposition (Name of y, crematory or other place)	Date 20c	Location - City or To	own, State
Baltimore,	it. Pages intment of intent: If it injury or o		'4 Donation 5 Dother (Specify)  21. Signal re of Funeral Servis: Licens	Lorra	aine Park 12/2	1/2004 F	alto. 1	Md.
Ba	permit. Departn Importe any inju		alone of Pulleral Service License	L. Russ	Joseph L. Russ	uneral H	ome 21	216
				ications that caused the death. Do not not cause on each line.	ot enter the mode of dying, such as cardiac	c or respiratory arrest,	-110(1 -21	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co sequence o	nia			hours
	Examiner		Sequentially list conditions.	. Alzheir	ners			years
	uted d ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dug to for as a consequence o	f):			
30,	tificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a consequence o	f):			
68760,	ficate by physicas the b	edicai		j				
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ery Day Year
ords, P	equires that en signed b ould be deta		Part II. Other significant conditions co	ntributing to death but not resulting in	the underlying cause given in Part I.		co use contribute to the	41
Vital Records,	The lay ate has page 2	Completed				24a. Was an autopsy performed 1 Yes 2	7, death?	psy findings available mpletion of cause of
Vita	ysician: The I is certificate he director, page	Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ER/Out	04	ath <i>(Check only one)</i> Iome 5 Residence	6 Flother (Cassif	
Division of	Attending Physician: or death. ector: After this certific by the funeral director.	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 8b. Ti		28d. Describe how in		y)
Divis	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street City or Town, St.	and Number or Rura ate)	il Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dirt completely filled in I	Medical (	29a. Certifier (Check only one) Certifying Phy (Check only one)	sician: To the best of my knowledge, ner: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	, and due to the cause irred at the time, date a	(s) and manner as st and place, and due to	tated. the cause(s)
	To the within 2 To the complet	) Z	29b. Signature and ittle of certifier	1	29c. License number	29d. (	Date signed (Month,	Day, Year)
1	18		30. Name and address of person who co	empleted cause of death (Item 23a) (	Type, Print) 0 04 0		11/24/6	74
1	/ ('		Seth Bunet 31. Date filed (Month, Day, Year)	22 S. Greene 32. Registrar's Signature	ST EXELT MD	21201		
	Sta Registr		DEC 0 1 20	. 7	& South			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		State of Maryland / Department		Mental Hygiene	01 07070
	AMEND TTEM #20b PE 1. Decedent's Name (First, Middle, Las	R FH G838 12/07/04ertificate	of Death	Reg. Ne U	U4 37878
Physicia /Medica	n David Co	lline		Month Day November 23,	3. Time of Death 2004 17:35
Examine	4a Facility Name (If not institution, give		4b. City, Town, or Le		ity of Death
•	5200 block Pulask		Perryvi		ecil
Funeral Director	5. Social Security Number 6. S 219-50-6007 1 Usual Residence of Decedent		Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month, Day, Year, June 6, 1950	9. Birthplace (State or Foreign Country)  Mary and
aryland show	10a. State 10b. County	10c. City, Town or Location			10d. Inside City Limits
the Maryle 28e-f sho	10e. Street and Number 10e. Street and Number 11. Marital Status 1 Never Married 2 Married	A Baltim	ore		1)AYes 2□No
with the	10e. Street and Number	1 / O 1	lode	10g. Citizen o	f What Country?
leath w	5605 705e	12. Was Decedent Ever in U.S. 13. Was Deceden	nt of Hispanic Origin? (So	egify Yes or No. 14 B	ace - American Indian,
5-0020 72 hours efter death with the Maryland naturel", or items 23e or 28e-f show deal Evaniner must be notified at	1 Never Married 2 Married 3 Widowed 4 ADivorced	Amied Forces? If Yes, specify 152 Yes 2 □ No If Yes, Give 1 □ Yes 2 Year or Dates:	nt of Hispanic Origin? (Sp y Cuban, Mexican, Puerto No Specify:	Rican, etc.)	ack, White, etc.
21215-0020 d within 72 hours of giene. or than "netural", or the Medical Exam	15. Decedent's Ed	ucation 16a, Decedent's Usual 0	Occupation	. 16b. Kind of	DICC Business/Industry
within 7	(Specify only highest grad	College (1-4or 5+)  (Give kind of work life. DO NOT use	done during most of work retired)	ing /	1
a filed will Hygien other the	17. Father's Name (First, Middle, Last)	0 Machin		ator ta	ctory
Maryland d 2 should be file th and Mental Hyg 7 is marked othe treumatic event,	o 17. Father's Name (First, Middle, Last)	Ituas Cr	18. Mother's Name	e (First, Middle, Maiden Surna	(me)
Marylar 12 should be n and Menta 18 marked reumatic ev	19a. Informant's Name/Relationship (T	ype, Print) (SISTER) 19b. Mailing Address (S	Street and Number or Ruri	al Route Number, City or Tow	n, State, Zip Code)
ore, M	Mrs. Sulvia	Hawkins 3834 T	Boarmai	n Ave. Bal	to. Md. 21215
S T S E	20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ I	20b. Place of Disposition (Name cemetery, crematory or othe	of er place)	2/03/04 Oc. Location	- City or Town, State
<b>₹</b> 8 8 4 5	4 ☐ Donation 5 ☐ Other (Specify	Garrison	Forest -	16/2004 Owin	gs Mills, Md.
Balti permit. Depertm Importer eny Injun	21. Signature of Funeral Service Licens	22. Name and Joseph	Address of Equility	Funeral Ho	me.
	23a. Part). Enter the disease, or comp	ications that caused the death. Do not enter the mode	(North A	ve Balto, 1	Md. 21216
Physician	shoely, or heart failure. List only o	ications that caused the death. Do not enter the mode one cause on each tine.	n dying, such as cardiac c	or respiratory arrest,	Approximate Interval Between Onset and Death
/Medical	Immediate Cause (Final disease or condition	Multiple ins	uns		1
Examiner	resulting in death)	Due to (or as a consequence of			<u> </u>
bed is		b			
I Records, P.O. Box 68760, The law requires that the death certificate be executed steen signed by the attending physician and page 2 should be deteched for use as the bunal-trensit.	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):			
68760, ifficete be example of the purial graph sician gas the burial Ex	Cause (Disease or injury that initiated events	Due to (or as a consequence of):			
ntifice	resulting in death) Last				1
Box 6 eath certific attending p		d			
that the death cert ed by the attending deteched for use	Part II. Other significant conditions con	stributing to death but not resulting in the underlying cause	se given in Part I.		ontribute to the cause of death?
ds, P.				1 ☐ Yes 2 🔼 No	3 ☐ Probably 4 ☐ Unknown
of Vital Records, Physician: The law requires the certificate has been signed injector, page 2 should be completed by				24a. Was an autopsy	24b. Were autopsy findings
The law requir				performed?	available prior to completion of cause of death?
				1XYes 2□No	1A Yes 2□ No
Of Vita Physician: this certific ral director,		lospital:	26. Place of Death		, , , , , , , , , , , , , , , , , , ,
Physic rithis control direction of L	123 165 2 140	1 Unpatient 2 ER/Outpatient 3 DOA		ne 5□ Residence 6 🖾ot 28d. Describe how injury occu	
Division of the or Attending P is effect death.  The or Attending P is effect of the transfer is of the truers of the order of the truers.  Certification:	1 □ Naturat 5 □ Pending 2 X Accident investigation	(Month, Day Year) Injury ( (U/23/04 5'2) M		nesject struck	
IVIS retore by the	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)			ber or Rural Route Number, OD Pulas Kg Highway
Distal or rat Dir		speet		perguide, my	1
Divisit To the Hospital or Attent within 24 hours efter death to the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier 1 Certifying Physical Check only one)	ician: To the best of my knowledge, death occurred at ther: On the basis of examination and/or investigation, in and manner stated.	he time, date and place, a my opinion, death occurre	nd due to the cause(s) and med at the time, date and place,	anner as stated. and due to the cause(s)
To the within 2 To the comple	29b. Signature and title of certifier		icense number	29d. Date signe	ed (Month, Day, Year)
	1 Tabrille	& Ali	O.C.M.E.	Novembe	r 24, 2004
11/1/	0. Name and address of person who co	mpleted ceuse of death (Item 23e) (Type, Print)			A - A - A - A - A - A - A - A - A - A -
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	treet, Balti	more, Marylan	d 21201
Registrar	DED A + a-	14 Beneva &			
DHMH 16 Rev 6/95		- Agos	illa)		

**ORIGINAL** 

			For 1 State	State	e of Maryla	•		t of H	lealth a	and M	ental Hyg	giene leg. No.2 (	) N L	378	370
			Registrar  1. Decedent's Name (First, Middle	. Last)		00.	tinoati	0 0 7 2	Jean		2. Date of Dea	ith	204	3. Time of	Death
	Physici		Loa M. Du	-							Nov. 28	. 2004	Year	6:30	АМ
	/Medio Examin		4a. Facility Name (If not institution,		d number)		4b. City,	Town, or	Location				nty of Death	10.00	
	_Adiiii.		Manor Care Du	ılaney				To	wson			В	altim		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2X	E	s. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day	(, Year)		place (State or ntry)	r Foreign
	Director		215-12-1500 Usual Residence of Decedent	1 C W 2 C		B6 Yrs.					Dec. 9,	1917	Mary	yland	
	land ow		10a. State 10b. County		10c.	City, Town or Lo	ocation							10d. Inside Cit	y Limits
	Mary -1 sh	ţō	Md. Bal	timore			Тоы	son						1 □ Yes	2 <b>X</b> No
	or 288	Funeral Director	10e. Street and Number	COLINOTO			10f. Zip					10g. Citizen o	of What Cou	ntry?	
	th wit	aiD	30 Acorn Circ	cle Apt	t. 101				21286				USA		
	r dea	ne	11. Marital Status	Arme	Decedent Ever in d Forces?	U.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	ispanic Ori In, Mexicar	igin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)	14. R	ace - Ameri lack, Whit <i>e</i> ,		
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☑ Divorced	If Yes	es 2 XNo s, Give or Dates:		1 🗌 Yes	2 🔀 No	Specify:			Spec	cify:	White	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-1 show Ita Madical Examiliar inual be mullified al	edt	15. Decedent			16a. Dece	dent's Usua	al Occupa	ation			16b. Kind of			
215	hin 72	ple	(Specify only highes Elementary/Secondary (0-12)			(Give	kind of wor DO NOT us	rk done d se retired	during mos ()	SE OF WORKI	ng			& Indu	_
21	giene giene r th	Completed		2	ge (1-4or 5+)		Inves	tiga						aryland	<u>1</u>
nd	be filk tal Hy d oth	Be	17. Father's Name (First, Middle, I								(First, Middle,				
<u>Ş</u>	should be filed with nd Mental Hygiene, marked other than umatic event, ILE	70	Lawrence Le			10h Maili	na Addross	/Street			B <b>ryan G</b> <i>I R</i> oute Numbe			n Code)	
Maryland	d 2 sho th and th ema traum		19a. Informant's Name/Relationsh								r Sprin				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or iteme 23a or 28a-1 show any njury or other traumatic event, It is Mudical Examinist count be notified at ODGs.		Mr. Daniel Baldu 20a. Method of Disposition		20b	Place of Dispo cemetery, cre	dhurs	ne of			ate	20c. Location	n - City or To	own, State	
JO L	Pages ent of nt: if I		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St		rom State	illtop				12/1	/04	Towson	Mary	vl and	
Baltimore,	permit. Pa Departmer Importent: any injury		21. Signature of Funeral Service I		0		2. Name an				ck Tows				inc.
m	Departiment Department		micha	117	2nd		050 Y			To	wson, M	arylan			
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications to only one cause	hat caused the de on each line.	eath. Do not en	ter the mod	e of dyin	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Bety Onset and D	ween
	Physician		Immediate Cause (Final disease or condition	_ a N	lyoca	ardia	l Iv	rfo	irct	ion				Onsor and E	rouii i
	/Medical Examiner		resulting in death)	Du	e to (or as a cons	equence of):									
		er	Sequentially list conditions, if any, leading to immediate	b. — Du	e to (or as a cons	equence of):					·				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
oʻ	te be executed ysiclen and te burial-transit	Exa	resulting in death) Last	Du Du	e to (or as a cons	equence of):			-						
3760,		Ical		d								<del></del>			
89 x	entific ling pl	Mec	IF FEMALE:	00a Huna											
Вох	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	101	s, outcome of precive birth 2 ☐ Fi Pregnant at time o	etal death 3	Ectopic pr						Date of deliv Month	-	'ear
P.O.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	1 ☐ Yes 2 ██No 9 ☐ Unknown		Jnknown	T GOZETT O									
	that ned by deta	by Ph	Part II. Other significant condition	ns contributing	to death but not r	resulting in the u	inderlying c	ause give	en in Part I	l.	23e. Did to	bacco use co	ntribute to t	he cause of de	aath?
rds	w requires that been signed to should be det	ed b									1 🗆 Y	es 2□No	3 🗌 Prot	pably 4 🕮	nknown
Records,	aw re	Completed									24a. Was		. Were auto	opsy findings a	avaitable
H.		E O									perfor	med?	death?	2 No	
Vital	sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?					0.1		e of Death	(Check only o	ne)			
of \	Phy this al d	2	1 Yes 2 No		1 Inpatient 2				4 4		ne 5 Resid			fy)	
n C	Jing Afte fune	lon	27. Manner of Death  1 ☐ Natural 5 ☐ Pendin 2 ☐ Accident investig		Date of Injury Month, Day Year,	) Injury	M	8c. Injury Work	k? Yes 2□		.bu. Describe i	ON IIII OCC	direc		
Division	Attending r death.	flca	3 Suicide 6 Could	not be 28e. F	Place of Injury - A	t home, farm, st					28f. Location (S		mber or Rura	al Route Numb	ber,
Ö	afor after i Dire	erti	4  Homicide		ouilding, etc. (Spe	ecity)					City or Tou	n, State)			
	ospita hours unera ly fille	cal	29a. Certifier 1 Certifyin	g Physician: T	o the best of my k	cnowledge, dea	th occurred	at the tin	ne, date ar	nd place, a	and due to the	ause(s) and	manner as s	stated.	1
	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Certification;	one)	and	manner stated.	dion and of II									
	To To	2	29b. Signature and title of certifier	P	CM	0.0.			e number	24		29d. Date sigi 11-30		Day, Teal)	
,	1 10	1						005	777	27		- 50			
1	3 11		30. Name and address of person	who completed 20 E.	Timon	um rd	# ZC	9 1	imoi	nun	MD	21093	3		
	Sta	ate	31. Date filed (Month, Day, Year)		32. Registrar's Sig										
	Regist		DEC 0 1	2004	Sener	~ B	So	ock	2						
_					/	/	1 0		_						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** THELMI /Medical 4c. County of Dea 4b. City, Town, or Location of Death Examiner MORE If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 6. Sex **Funeral** Hours 1 □ M 2 🗗 -10-Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County traumatic event, the Medical Examiner roust be notified at 1₽ Yes 2 No Director 28a-f 10g. Citizen of What Country? 10f. Zip Code ö 238 Completed by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black, White, etc. ☐Yes 2☐No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ö If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) is marked other than College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental CORNISH P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar trai 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ZION <sup>¹</sup> 4 □ Donation 5 ☐ Other (Specify) 21. Signatur BACTO, MD SIDET sease, or complications that caused the dearnilure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, ate ause (Final Pnysician Alzheimers disea ( condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit or Attending Physician: The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnt 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) Yes 2 Kg o. 9 Unknown 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 (Unknown 24b Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Beath (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? completely filled in by the funeral 27. Manne of Death 28b. Time of 28d. Describe how injury occurred : After Injury 5 Pending 1 atural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral L To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainto. So seems 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 57465 12/1/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21136 .S. Rajapakce MD 25 Main St. Suite 200 - Reisterstown 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 001

	State of Maryland / E	Department of H  Certificate of L	ealth and Menta Death	Al Hygiene	3788
Physician /Medical	1. Decedent's Name (First, Middle, Last)  SR. M. MONICA DERES, MHSH		2. Det Mo	e of Deeth onth Dey Year	7 7 7 4
Examiner	4a Fecility Neme (If not institution, give street end number) THE VILLA		b. City, Town, or Location of Rodgers Forg	of Deeth 4c. County of Dee	
Funeral Director	5. Social Security Number 213-74-8125 6. Sex 1		If Under 24 Hrs. 8, Dat	e of Birth 9. Bi	nthplace (State or Foreig Tountry) W Jersey
72 hours after death with the Maryland natural, or items 23s or 28s-1 show dical Examiner must be notified at each by Funeral Director	Usuel Residence of Decedent  10a. State  10b. County  10c. City, Town  Maryland  Baltimore County  10c. City, Town  Roce  10c. Street and Number	dgers Forge	01010	10g. Citizen of What C	-
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  Important: If then 27 Is marked other than "natural; or items 23a or 23a-f show any Injury or other traumatic event, the Madical Examine mant be notified at once.  To Be Completed by Funeral Director	6808 Bellona Avenue  11. Meritel Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		21212 spanic Origin? (Specify Ye, h, Mexican, Puerto Rican, e Specify:		erican Indian,
filed within 72 how Hygiene.  ther than "natura out, the Madical out, the	15. Decedent's Education (Specify only highest grede completed)  Elementary/Secondery (0-12)  College (1-4or 5+)  Ror	Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired)	uring most of working Nun	16b. Kind of Business Christian	
should be filed and Mental Hygis i marked other umatic event, to To Be Co			Johanna	Middle, Maiden Sumame)  Krause	
ages i end 2 si nt of Health an t: If Item 27 Is n y or other traur	Sr. Loretta Cornell, MHSH 10  20a. Method of Disposition  1 \overline{X} Buriel 2 \overline{\text{Cremetion}} 3 \overline{\text{Removal from State}} \end{array} 20b. Place of cemetery	001 W. Joppa Disposition (Name of y, cremetory or other place	Road, Towso	Number, City or Town, Stete, n, Maryland 21 20c. Location - City or	204 Town, State
Departme Important any Injury DRCe.	21. Signatury of Funeral Service Tipenese  Martin D. Lawson  23a. Pert1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	22. Name and Address	of Facility Utiodo fold Tru	2004 Baltimore neral Home, Ir more, Marvland	10
hysician /Medical Examiner	23a. Perf1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Ceuse (Final disease or condition resulting in deeth)  Due to (or es e condition to the conditio				Approximate Interval Between Onset end Death
ettending physician and drouse as the buriet-trensit clan/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest  b. Peruphera  Due to (or es e co	onsequence of):	disage		170
Φ 60	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause give	n in Part I. 23b	o. Did tobacco use contribute	to the cause of death
P P P			249		robably 4 Unknow
mp hes				performed?	available prior to completion of cause of deeth?
his certifice al director, I	25. Wes case referred to medical examiner?  1 Yes 2 No  27. Menner of Death 1 Natural 5 Pending (Month, Dey Year)  1 Natural 5 Pending (Month, Dey Year)	patient 3□ DOA Other me of 28c. Injury	4 Indisting Home 5		1 □ Yes 2 ☑ No
within 24 hours efter death.  To the Funeral Director: After t completely filled in by the funer  Medical Certification:	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide   Could not be determined   28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 □ Ye	es 2 □ No 28f. Loca	ttion (Street and Number or Ru or Town, State)	ural Route Number,
within 24 hours effective the Funeral Direction Completely filled in Medical Cert	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination end/end manner stated.	death occurred at the time for investigation, in my opin	, date end place, and due to nion, death occurred at the	to the cause(s) and manner as time, date and place, and due	steted. to the cause(s)
within To th comp	29b. Signeture end title of certifier  Mich — 0 14 ye		number 86 J	29d. Date signed (Month	
2	30. Name and address of person who completed cause of death (Item 23e) (The second sec	ype, Print) Mien	D. Kioune, M.	1.D. 2/20/	
State Registrar	31. Dete filed (Month, Dey, Year)  BEC 0 1 2004  32. Registrer's Signature	o spain			-

			State of Maryland / Department of Health and M	lental Hygien	e 2001 27002
			1 - State Registrer Certificate of Death  1. Decedent's Name (First, Middle, Last)	Reg. N	4 3. Time of Death
	Physici /Medic		ROBERT DUNN	NOVEMBER	ay 26 2004 2:30AM
	Examin	er	4a. Facility Name (If not institution, give street and number)  NORTHWEST HOSPIAL CENTER RANDALL STUE	ا ادر	BALTIMORE.
	Funeral Director		5. Social Security Number 6. Sex 1 $\boxed{A}$ 1 $\boxed{A}$ 3 $\boxed{A}$ 3 $\boxed{A}$ 6. Sex 1 $\boxed{A}$ 4 $\boxed{A}$ 6. Sex 1 $\boxed{A}$ 4 $\boxed{A}$ 6. Sex 1 $\boxed{A}$ 4 $\boxed{A}$ 6. Sex 1 $\boxed{A}$ 6. Sex 1 $\boxed{A}$ 7. Age (In yrs. last birthday) $\boxed{A}$ 1 $\boxed{A}$ 4 $\boxed{A}$ 6. Sex 1 $\boxed{A}$ 4 $\boxed{A}$ 7. Age (In yrs. last birthday) $\boxed{A}$ 4 $\boxed{A}$ 6. Sex 1 $\boxed{A}$ 6. Sex 1 $\boxed{A}$ 7. Age (In yrs. last birthday) $\boxed{A}$ 4 $\boxed{A}$ 6. Sex 1 $\boxed{A}$ 7. Age (In yrs. last birthday) $\boxed{A}$ 6. Sex 1 $\boxed{A}$ 6. Sex 1 $\boxed{A}$ 7. Age (In yrs. last birthday) $\boxed{A}$ 8 $\boxed{A}$ 8 $\boxed{A}$ 8 $\boxed{A}$ 9 $\boxed{A}$ 8 $\boxed{A}$ 9 $\boxed{A}$	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)  151 Maryland
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location		10d. Inside City Limits
	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show offed Exer, free rout be notilled at	Director	Maryland Baltimore Randallstown	10g. C	1 XYes 2 No
	th with		9109 Liberty Rd. 21133		USA
	ter dea Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	ours af	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: Black
21215-0036	C 2	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Spcondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working inference in the properties of the	16b.	Kind of Business/Industry
d 21	illed with Hygiene. other thar		17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maide	estaurani In Sumame)
/lan	should be ind Mental imarked o	To Be	James Dunn Sr. Alber	ta Bi	-ake
Maryland	and and Is m	·	19a. Informant's Name/Relationship (Type, Print) nephew)  19b. Mailing Address (Street and Number or Rura  19c. Mark Mark Mark Market and Number or Rura	I Route Number, City	or Town, State, Zip Code)
	es 1 and 2 of Health fitem 27 r other tr		cemetery, crematory or other place)	/	Location - City or Town, State
Baltimore,	Pag nent ant: I		'4 Donation 5 Other (Specify)	2004 La	nsdowne, Md.
Bal	permit. Departrimports any inju		AND LAND A WORLD FILE W. NOFTH AV	ineral He. Balto.	ma, and 16
			23a. Part). Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac of shock, or heart trillure. List only one cause on each line.		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a.   — EREBRO VASCULAR ACCID  Due to (or as a consequence of):	EU1	
E	Examiner	7.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
	cuted od ransit	Examine	Cause (Disease or injury that initiated events c.		
8760,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last  Due to (or as a consequence of):		
9	rtificate ng phys	Medic	IF FEMALE:		
Box	leath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No		23d. Date of delivery  Month Day Year
P.O.	at the de	Physi	9 ☐ Unknown	OG Did tobaco	and the same of death?
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  HYPERTENSION	1 Tes	use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Division of Vital Records,	The law re ate has be page 2 sho	Completed	SEIZURES.	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
'ital		Be Co	25. Was case referred to medical examiner?	1 Yes 2 N	o 1 ☐ Yes 2 ☐ No
of V	Phys r this ral dir	2	1 ☐ Yes 2 No Hospital: 1 Nunpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hor	me 5 Residence 28d. Describe how inju	
ion	ath. ath. or: Afte	atlor	Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No		
Divis	s after death. s after death. al Director: After the in by the funera	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Sta	nd Number or Rural Route Number, re)
	Hospii 4 hour Funera ely fill	edlcal C	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause( ed at the time, date an	s) and manner as stated. Id place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and time of certifier PHYSICIAN 29c. License number D42723.	MOVE	
1	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTHWEST AVY ERAHALLI MHARISH 5401 0LD (	OURT R	TAL CENTER.  CAD. MD 21133
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 1 2004  32. Pegistrar's Signature		

			For .	State of Maryland /	Department of H Certificate of I			- 0 0 7	37883
			Registrar  1. Decedent's Name (First, Middle, Last,	)	Certificate of t		Reg. N		3. Time of Death
	Physicia /Medic		Conscrt (	USANOS	3		Nov. 29	2004	248PM
	Examin	er	4a. Facility Name (If not institution, give	edical Center	D. 0	Location of Death	4	C. County of Death	) 2.
	Funeral Director		5. Social Security Number 6. Se. 218 - 48 - 23 8 3	7. Age (In yrs. last b	irthday) If Under 1 Year  Yrs. Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Year G - 24 - 19	47 Mar	place (State or Foreign
	pue *		Usual Residence of Decedent  10a. State 10b. County	10c. City. Toy	wn or Location				10d. Inside City-Limits
	Maryle 8-1 sho	tor	hd Balk		dlawn				1 ☐ Yes 25 No
	with the a or 28	Director	10e. Street and Number 3124 Jeffre.	, D o	10f. Zip Code	244	10g. C	Citizen of What Cou	untry?
	oms 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi		ify Yes or No-	14. Race - Amer Black, White	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Deperment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28e-f show important: if Item 27 is marked other than "attural; or Items 23a or 28e-f show any Injury or other traumatic event, The Madical Examinar must be notified at once.	þ	1 ☐ Never Married 2 ∰ Married 3 ☐ Widowed 4 ☐ Divorced	1 <b>1 1</b> Yes 2 □ No If Yes, Give Year or Dates:	1 □ Yes 2 No	Specify:		Specify: Bl	1
21215-0036	n 72 ho natur	leted	15. Decedent's Edu (Specify only highest grad	e completed)	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	during most of working	16b.	Kind of Business/li	ndustry
	ed withi /giene. er than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Salesma	n	1+		proxment
Maryland	ld be fill ental Hy ked oth	To Be	17. Father's Name (First, Middle, Last)	's Sc.		18. Mother's Name (	First, Middle, Maide	n Sumame)	
ary	2 shoul and Mis marl	<u>-</u>	19a. Informant's Name/Relationship (T)		b. Mailing Address (Street a	and Number or Rural	Route Number, City	or Town, State, Zi	ip Code)
	1 and Health em 27		20a. Method of Disposition	-ds wise 3	124 Jett	rey Kel,	59/10. te 20c. 1	Location - City or T	Own, State
<u>m</u>	Pages nent of int: if it		1 Burial 2 Cremation 3 F 1 Donation 5 Other (Specify)	temoval from State   🖍	ery, crematory or other place	1 17	2004 B	ito les	l.
Baltimore,	permit. Depertrainmports any inju		21. Signature of Funeral Service License	Wandan	2. Name and Address		Funera + Balk	Services. Med. 2	1217
			23a. Part1. Enter the disease, or compleshook or heart failure. List only of	ications that caused the death. Do		1			Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ChNCEN  Due to (or as a consequence	can be	er we	18315		Klowy P
	Examiner		Sequentially list conditions,	Care	erte B.	nain	Cive	1	
13	Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	orj.	,			
, 8260,	ficate be executed physicien end is the burial-transit	al Exa	resulting in death) Last	Due to (or as a consequence	of):				
9	g physical as the l	ledical	1	d					
Вох	es that the death certifigned by the attending be detached for use a	by Physiclan/Me	IF FEMALE: 23b, Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy				23d. Date of deliv	very Day Year
o.	t the de by the a	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 ☐ Other ( <i>specify</i> )				
ds, P	The law requires that the death certif lie has been signed by the attending page 2 should be detached for use a		Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause give	en in Part I.			the cause of death? bably 4 □Unknown
Vital Records,	law requir as been s 2 should	Completed					24a. Was an autopsy		opsy findings available ompletion of cause of
al	n: The ficate h	e Con	25. Was case referred to medical			00 81	performed?	death? o 1 ☐ Yes	2 NO
Ĭ.	nysicie iis carti directo	To Be	evaminer?	Hospital: 1 Inpatient 2 ER/O	utpatient 3 DOA Othe	26. Place of Death ( er: 4 ☐ Nursing Home	e 5 Residence	6 ☐Other (Speci	ify)
o uo	ding Pf h. After th funeral		27. Manner of Death  1 Natural 5 Pending 2 Paccident investigation	28a. Date of Injury (Month, Day Year) 28b.	Time of Injury Work	/ at 28 <br Yes 2 □ No	ld. Describe how inju	ary occurred	
Division of	or Attan	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, I building, etc. (Specify)			f. Location (Street a City or Town, Sta		al Route Number,
_	To the Hospitel or Attanding Physicien: The law within 24 burus after death.  To the Funerel Director After this certificate has completely filled in by the funeral director, page 2.	edical Ce	(Check only 2 Medical Exami	sician: To the best of my knowledger: On the basis of examination a	ge, death occurred at the time and/or investigation, in my op	ne, date and place, an pinion, death occurred	id due to the cause( I at the time, date ar	s) and manner as :	stated. to the cause(s)
	To the within 2 To the comple	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License	number	29d. D	ate signed (Month,	Day, Year)
			MBK	rufter	· DI	3779	( )	125 ~	· 10
	5×1		30. Name and address of person who co	1 4 M 1 5 W 2 S	5400	0/2 Co	art sa	. baltop	ud. 21244
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 1 2	32. Redistrar's Signature	foot			·	

			. For		aryland / Dep			•	•	ole.	
			State Registrar		Се	rtificate of	Death	R	eg. No. Z U	U4	37881
	Physici	an	1. Decedent's Name (First, Middle, L					2. Date of Dear Month	Day	Year	3. Time of Death
	/Media	cal	Dorris K. Ear			Ab Cib. Tours	a Lagrica of Dank	Novembe	1		3:10am <sup>™</sup>
4	Examir	ier	4a. Facility Name (If not institution, g			Towson	or Location of Deat	n	4c. County Balti		
	Europal		Greater Baltimor  5. Social Security Number 6.		ge (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthol	ace (State or Foreign
	Funeral Director		216-16-1603	1□ M 2□xF	81 Yrs.	Months Days	Hours Min.	8. Date of Birth July 23	, Ye 1923	Mary	Tand
	P .		Usual Residence of Decedent		10c. City, Town or L	conting				14/	Od. Inside City Limits
	show	٦	10a. State 10b. County								1 ☐ Yes 2 ☐ No
	the M	ecto	MD Baltimo	re	Cockeysvi	10f. Zip Code		1	0g. Citizen of V	Vhat Coun	
	with with		10535 York Road			21030			USA		,.
	death ms 2;	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of H	Hispanic Origin? (S	pecify Yes or No-		- America	
9	after or Its	F.	1 Never Married 2 Married	Armed Forces' 1 Tyes 2 X If Yes, Give	No	1 ☐ Yes 2 🛣 No		o nican, etc.)	Specify	k, White, e wh	<sup>∍ic.</sup> ite
003	urel',	d by	3 🛛 Widowed 4 🗋 Divorced	Year or Dates:							
15	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show he Madical Examinar must be notified at	lete	15. Decedent's (Specify only highest g	ducation rade completed)	16a. Dece (Give	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of word)	rking	16b. Kind of Bu	isiness/Ind	lustry
21215-0036	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ms	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	ce & Sale			Insura	nce	
	e filed al Hygi other vent, I	BeC	17. Father's Name (First, Middle, Las					me (First, Middle, I		ө)	
<u> a</u>	should be ind Mental s marked o	To	Charles A. Jone	S			Irene	Dobere	^		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryla tof Health and Mental Hygiene. If item 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at		19a. Informant's Name/Relationship			ing Address (Street					Code)
	1 and lealth sm 27 ther tr		Bonnie K. Hall 20a. Method of Disposition	/daug	hter 1001 20b. Place of Disp	Jessica'	s Court:		MD 21 20c. Location -		wn State
وَ	Pages nent of I int: If it		1 ☐ Burial 2 ☐ Cremation 3		cemetery, cre	ark Cemet	<sub>се)</sub> erv 12/		Baltimo		
Baltimore,			' 4 ☐ Donation 5 ☐ Other (Spec			22. Name and Addre					
B	permit. Departr Imports any inju		1 Peta 1	Clayer	R	uck Towso	n Funera	1 Home	1050 Towso		21204
	182		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications in t cause					est,	100	Approximate Interval Between
М	Physician		Immediate Cause (Final disease or condition	P	neville	ma					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):						
	LAMITHIE	_	Sequentially list conditions,	b. Due to (or as	a consequence of):					_	
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (0) 4.	a consequence or.						
΄,	execun and ial-tra	Exar	that initiated events resulting in death) Last	c.  Due to (or as	a consequence of):						
,092	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cail		d							
89	rtifica ng ph	Medi	IF FEMALE:								
Box	ath ce ttendi or use	lan/l	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnanc	у		23d. Dat Mor	e of delive	ry Day Year
0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9□Unknown	t time of death 5	Other (specify) _					,
<b>Q</b>	that the detact	by Physician/Med	Part II. Other significant conditions	contributing deat	ut fot resulting in the	by derlying cause give	ven in Part I.	23e. Did tol	pacco use contr	ibute to the	e cause of death?
Records,	quires n sigr uld be	q pa	Part II. Other significant conditions	uou fo	SMELON	nou		1 🗆 Ye	s 2 No	3 🗌 Proba	ably 4 🖺 Unknown
000	aw rec s bee 2 shou	piete	- 50	ware	CUPIS			24a. Was a		Vere autop	osy findings available inpletion of cause of
R	The ta	Completed						autops perform	ned? c	leath?	
Vital	sian: Brtifica Ictor, I	Bec	25. Was case referred to medical examiner?					ath (Check only on	e)		
of C	physic this cal	ဥ	1 ☐ Yes 2 ☑ No	Hospital: 1 Mnpat		INT 3LI DUA		lome 5 Reside			)
Division of	ding F	ion	27. Manuar of Death  1 Vinatural 5 Pending 2 Accident investigati	28a. Date of Inj (Month, Da	ay Year) 28b. Time injury	Wo	ryat rk? ]Yes 2 ☐No	28d. Describe ho	w injury occurr	ea	
/ISI	death death ctor:	fical	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Ir	ijury - At home, farm, s			28f. Location (St		er or Rural	Route Number,
D.	al or safter	Certification;	4 - Homicide determine	building, e	tc. (Specify)			City or Town	n, State)		
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying I	hysician: To the bes	t of my knowledge, dea of examination and/or i	th occurred at the ti	me, date and place	and due to the course d	ause(s) and ma	nner as sta	ated.
	the H the F the F nplete	dedical	one)	and manner s							
h h	T wit	1	29b. Signature and title of certifier	adou.	M	29c. Licens	7.32	2	9d. Date signed	FINO	(
•	0110		70 Name and address /	a completed source of	death (Item 22-) (Time	Print)		4	"//		
	M,		CIE01.02 1. 2	BESON T	13 670	1 N.Cl	racles &	T. Ball	Suoa	, Ad	, 21208
	Sta Regista		31. Date filed (Month, Day, Year)  DEC 0 1 200	1 4	rar's Signature	South	d				

Funeral Director  Page 1991	imore  9. Birthplace (State or Foreign Country) 27 Maryland  10d. Inside City Limits 1□Yes ¾√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√
Social Security Numbers    Social Security Numbers   Social Security N	9. Birthplace (State or Foreign 27 Maryland  10d. Inside City Limits 1 Tes Arrows Nhat Country?  States 10d. Inside City Limits 1 Tes Arrows 10d. Inside City L
Gwyndolyn L. Reynolds (Daughter) 1035 Florida Avenue, Hagerstown, Margerstown, Marg	Nhat Country?  States Be - American Indian, ck, White, etc.  White usiness/Industry aboratory Be)  State, Zip Code) ryland 21740 City or Town, State Maryland
Gwyndolyn L. Reynolds (Daughter) 1035 Florida Avenue, Hagerstown, Margerstown, Marg	se - American Indian, sk, White, etc.  White usiness/Industry aboratory ne)  State, Zip Code) ryland 21740 City or Town, State Maryland
Gwyndolyn L. Reynolds (Daughter) 1035 Florida Avenue, Hagerstown, Margerstown, Marg	aboratory  State, Zip Code)  ryland 21740  City or Town, State  Maryland
Gwyndolyn L. Reynolds (Daughter) 1035 Florida Avenue, Hagerstown, Margerstown, Marg	State, Zip Code) ryland 21740 City or Town, State Maryland
20a. Method of Disposition   Date   D	City or Town, State  Maryland
Physician / Medical Examiner  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death)  25a. Limediate Cause (Final disease or condition resulting in death)  25a. Limediate Cause (Final disease or condition resulting in death)  25a. Limediate Cause (Final disease or condition resulting in death)  25a. Limediate Cause (Final disease or condition resulting in death)  25a. Limediate Cause (Final disease or condition resulting in death)  25b. Limediate Cause (Final disease or conditions resulting in death)  25c. Limediate Cause (Final disease or conditions cause (Final disease or conditions)  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Under the mode of dying, such as cardiac or respiratory arrest.  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25c. Due to (or as	cal DirectorsInd
Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury that initiated events resulting in death) Last  Course (Disease or injury	Approximate Interval Between Onset and Death
Second   S	
	e of delivery nth Day Year
24a. Was an 24b. V	ribute to the cause of death? 3 Probably 4 □Unknown
Performed 1 Ves 2 Mag 1	Nere autopsy findings available prior to completion of cause of leath?  Yes 2 No
27. Manger of Death 28a. Date of Injury (Month, Day Year)  1 Watural 28d. Describe how injury occurr	or (Specify) ad
To the first of the last of my knowledge death conversed to the last of my knowledge death conversed to the last of an and also and due to the last of my knowledge death conversed to the last of an and also and due to the last of my knowledge death conversed to the last of an and also and due to the last of my knowledge death conversed to the last of an and also and due to the last of my knowledge death conversed to the last of an and also and due to the last of an analysis of the last of an analysis of the last of an analysis of the last of an analysis of the last of an analysis of the last of an analysis of the last of an analysis of the last of an analysis of the last of an analysis of the last of an analysis of the last of t	nner as stated
Novemb	ind due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  J Boston Northwest Hospital Center Randallstown, Mar  State  Registrar  DFC 0 1 2004  Augustus  A Arabal	(Month, Day, Year) er 26, 2004

DHMH 17 Rev 1/2001

Fletcher

<u>ъ</u>

Dorothy

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 37886

			Certificate of Death	Reg. No.	01000
5	Physician	1. Decedent's Neme (First, Middle, Last)  Elizabeth  E.	Foster	2. Dete of Deeth  Month  Day  Year  11  28  2004	3. Time of Death 6:15am
	/Medical Examiner	4e Fecility Name (If not institution, give street end number)  Keswick Multicare	4b. City, Town, or Baltir	Location of Death 4c. County of Dec	eth
	Funeral Director	5. Social Security Number 6. Sex 1 Age (In yrs. I	lest birthdey) If Under 1 Year If Under 24 Hrs Months Deys Hours Min.	8. Date of Birth (Month, Dey, Year) 9. Bi	irthplece (State or Foreign Country) N.C.
	D G	Usual Residence of Decedent	y, Town or Location	1100,	10d. Inside City Limits
	the Men 28a-f sh potitiod ector	Md. NA	Baltimore	10g. Citizen of What C	Y Yes 2 No
	ath with 123s or west being	2301 Pentland Dr. Apt. 312	21234	USA	
020	ges 1 end 2 should be filed within 72 hours after death with the Merylend tof Health end Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 23a-f show or other traumatic event, the Medical Examinat must be notified at To the Completed by Funeral Director	11. Maritel Status  1 Never Married 2 Merried  3  Wildowed 4 Divorced  12. Was Decedent Ever in U; Armed Forces?  1 Yes, Give Year or Dates:	S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuben, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)  14. Raca - Am Black, Wh	
21215-0020	ithin 72 ho be. han "natur Medical	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Decadent's Usual Occupetion (Give kind of work done during most of wo life. DO NOT use retired)		
	12 should be filed within in end Mental Hygiene. Fis marked other than "r Iraumatic event, the Me. To Be Comple	8th grade  17. Fether's Neme (First, Middle, Last)  Samuel Edmonds	Homemaker  18. Mother's Nai  Linab	Own Home me (First, Middle, Maiden Sumame) tell Hard	
Maryland	should I	Samuel Editionals  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Re		
	il end 2 Health e tem 27 is other trai	Jerrelle F. Francois Daughter  20a. Method of Disposition 20b. Pl	4607 Mainfield Ave.,	Baltimore, Md. 21 Date 20c. Location - City o	214
Baltimore,	permit. Peges 1 end Department of Health Important: If item 27 eny injury or other ti pnce.	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ametery, crematory or other place) rbutus Mem. Park	12-1-04 Arbutus	
Balt	permit. Pe Departmen Important: eny injury pnce.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Baltimore, Md.	
	<b>HELES</b>	23a. Part1. Enter the disease, or complications that cheed the death shock, or heart failure. List only one ceuse on each inches.	March F.H. East  Do not enter the mode of dying, such as cardia	1101 E. North A c or respiratory arrest,	Approximate Interval Between
	Physician /Medical	The state of the s			Onset and Death
5	Examiner 5	disease or condition resulting in death)  e. Due to (or	essure dementer as a consequence of):		gan
30x 68760,	eath certificete be executed attending physician and for use es the burlet-transit clan/Medical Examiner	if eny, leading to immediate cause. Enter Underlying Cause, Disease or injury	r es e consequenca of): r es a consequence of):		
P.O. B	the dea y the at sched fo	Part II. Other significant conditions contributing to death but not resu		23b. Did tobacco use contribut	te to the cause of death?  Probably 4 Unknown
	v requires thet the death been signed by the atte should be deteched for leted by Physicia		with Autic Stenosis		-
of Vital Records,	S 2 0	multiple strakes,	Hypertersion	24a. Was an autopsy performed?	Were autopsy findings aveilable prior to completion of cause of deeth?
alR	icete h	Venal Failure  25. Wes case referred to medical	00 81(8)	1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No
<u>&gt;</u>	hysician: nis certific il director To Be	examiner?	Other	eth <i>(Check only one)</i> Home 5□ Residenca 6 □Other <i>(Sp</i> e	ecify)
ion o	ath. r: After thi e funeral	27. Menner of Death  1 Natural 5 Pending (Month, Dey Year)  2 Accident investigation	28b. Time of lnjury M	28d. Describe how injury occurred	
Division	s efter de in Directo ad in by th	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At ho building, etc. (Specify	ome, farm, street, factory, office	28f. Location (Street end Number or F City or Town, State)	Rural Route Number,
	To the Hospital or Attending Physician: The is within 24 hours efter death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.  Medical Certification: To Be Com	29a. Certifier (Check only one)  1X Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinate end manner steted.		urred at the time, date and placa, and du	ue to the cause(s)
	To the within	29b. Signature end title of gertifier  A Shark hand les	29c. License number  D25205	29d. Date signed (Mon	nth, Day, Yeer)
1	31	30. Name and address of person who completed cause of deep (Item	6701 N. Charles	November St. Balts Md	21205
1	State Registrar	31. Date filed (Month, Day, Year)  32. Registrer's Signat			,

6:15 am

11-28-04

Elizabeth

FOSTER,

			1- State of Maryland / Departr	ment of Health and Ment icate of Death	aı Hygiene Reg. Ne	
	Physici	an	Decedent's Name (First, Middle, Last)		ate of Death Da	Year . Tyned Death
	/Medic		John Ford		11 20	1 2004 10:00 P M
	Examin	er		City, Town, or Location of Death	40	County of Death Baltimore
	Funeral		Riverview Care Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	Essex Under 1 Year If Under 24 Hrs. 8. Da	ate of Birth	9 Birthplace (State or Foreign
	Director		166 20 4612  Usual Residence of Decedent	onths Days Hours Min. (N	onth Day, Year C. 5, 192	9. Birthplace (State or Foreign Country) Pennsylvania
	yland		10a. State 10b. County 10c. City, Town or Location	on		10d. Inside City Limits
	e Mar e-fst	ctor	Maryland Baltimore Essex			1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number	Of. Zip Code		tizen of What Country?
	s 23a	erai	945 Martin Rd.	21221		USA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 le marked other then "naturel', or items 23a or 28e-f show any figury or other treumatic event, ite M. dical Exciding Intelligit at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No. If Yes 2 No. If Yes, Give WW II 1	Decedent of Hispanic Origin? (Specify Ys, specify Cuban, Mexican, Puerto Rican  Yes 2 No Specify:	, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Ş	2 hou	ted	15. Decedent's Education 16a. Decedent's	s Usual Occupation	16b. k	(ind of Business/Industry
Maryland 21215-0036	1 within 7 piene. r then "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Truck	of work done during most of working NOT use retired)  Driver	Ste	el Distributor
פ	be filed ital Hygi od other event,	Be C		18. Mother's Name (Firs.	t, Middle, Maider	Sumame)
ylai	should b ind Ments marked umatic e	To	Joseph Albert Ford	Florence I	ong	
	and 2 sho salth and n 27 le m			ddress (Street and Number or Rural Rourtin Rd. Baltimore,		
ore	of He of He fiterr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition cemetery, cremator	n (Name of Date ry or other place)	20c. L	ocation - City or Town, State
Ĕ	Pages Iment of Ient: If it jury or o		'4 Donation 5 Other (Specify) Sacred Hear	rt Of Jesus 12/3/200		timore,Maryland
Baltimore,	permit. Departr Importe any inju		21. Signalur of Funeral Service Licensee 22. Na Bruz 140	me and Address of Facility Zdzinski Funeral Ho 7 Old Eastern Avenu	ome P.A. ue Essex	, Md. 21221
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the chock, or heart failure. List only one cause on each line.	e mode of dying, such as cardiac or resp	piratory arrest,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Hetastatic luminesting in death)	ng and neck co	richo	nce I yes.
	/Medical Examiner		Due to (or as a consequence of):	•		•
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	cuted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
o,	ificate be executed g physician and as the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of);			
68760,	ate be hysici the bu	ledicai	d			
9 xo						004 D. 1 ( 4-1)
മ	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	opic pregnancy ner (specify)		23d. Date of delivery  Month Day Year
P.O.	at the	Phys	9 Unknown			
	ires th	by	Tarris one significant content of the single	lying cause given in Part I.	3e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?  No 3 Probably 4 Onknown
Records,	requi	Completed	T q parties state		-	
Rec	ne law has l ge 2 s	mp	Pysphage		4a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
<u>a</u>	in: Th	မ ငိ	25. Was case referred to medical		Yes 2	1 Yes 2 No
>	ysicie s cert direct	o B	examiner?	26. Place of Death (Che		6 ∏Other (Specify)
סר	Attending Physicien: sr death. ector: After this certifics by the funeral director, t	n: T			escribe how inju	
Sio	eath. or: Af	catic	2 Accident investigation M	M 1 Yes 2 No		
Division of Vital	al or Att	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, for building, etc. (Specify)		ocation (Street ar ity or Town, State	nd Number or Rural Route Number, 9)
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occ and manner stated.	curred at the time, date and place, and du gation, in my opinion, death occurred at t	ue to the cause(s the time, date an	) and manner as stated. d place, and due to the cause(s)
	ro the vithin ro the	Me	29b. Signature and title of certifier	29c. License number	29d. Da	te signed (Month, Day, Year)
	, 1		Hickory Comand	D19667	11-	30.2004
	ILLI.		30 Name and address of person who completed cause of death (Item 23a) (Type, Print			30.2004. Buring, Md 21061
	41	1	Three Sumanno 7310 lit	due 14 Junoray #50	8 Gleu	Borne, Md 21061
	Sta Registr		31. Date filed (Month, Day-Year)  32. Registrar's Signature	•		
DH	MH 17 Rev 1/2		DEC 0 1 2004 Senera &	back		
211	17 119V 1/21	001	ORIGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 28 2004 9:40 Gunzinger November Irene Therese /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice of Baltimore Gilchrist Center Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 16, 19 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 K F Director 75 1929 144-22-0601 New Jersey Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "naturel", or Items 23a or 28a-f show treumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 X No Directo Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Sandview Court 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐ Yes 2 💢 No If Yes, Give 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Management Academy Elementary/Secondary (0-12) College (1-4or 5+) 12 Branch Secretary Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental F Joseph Gunzinger Therese Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tret once. Gertrude M. Simeone / sister 1116 Rayville Road; Parkton, MD 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Gate of Heaven 12/2/04 21. Signature of Funding Service Licenses 1050 York Road 22. Name and Address of Facility Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter third-rying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 2 No 1 Tes 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} \) within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 25205 November 29, 2004 un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. Charles Street Baltimore, MD .21204 32. Registrar's Signature 31. Date filed (Mont State

DHMH 17 Rev 1/2001

Registrar

			Pol	epartment of Health and Me Certificate of Death		ene . No. 2004	37889
	Physici /Medic	al	Margaret Kathryn Graff  4a. Facility Name (If not institution, give street and number)		Month	Day Year 25 2004  4c. County of Dear	10:45 p M
	Examin	er	2303 Four Seasons Drive	Gambrills	Į	Anne Arun	
	Funeral Director		177 44 3012	Months Days Hours Min.	8. Date of Birth (Month, Day, Y Jan • 15,	(ear) 9. Bird Co 1910 Per	hplace (State or Foreign buntry) nnsylvania
	ryland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town				10d. Inside City Limits
	the Ma 28e-f s	ectol	MD Anne Arundel Ga	ambrills 101. Zip Code	100	. Citizen of What Co	1 ☐ Yes XXNo
	3a or	10	2303 Four Seasons Drive	21054	109	USA	ourti y r
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other treumatic event, the Medical Examinar must be notified at once.	d by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R     □ Yes 2 No Specify:	city Yes or No- lican, etc.)	14. Race - Ame Black, Whit	
Maryland 21215-0036	within 72 h ane. than "natu ha Medica	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) nemaker	g 16	b. Kind of Business  Own Home	
2 ع	e filed Il Hygir other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma.		
ylar	ould by Menta	To E	William Einhouse	Jane Dav			
Mar	id 2 sh Ith and 27 is m treum			Mailing Address (Street and Number or Aural  3 Four Seasons Drive			
Baltimore,	Pages 1 and lent of Health nt: if item 27 iry or other ti		20a. Method of Disposition  20b. Place of I cemetery	Disposition (Name of crematory or other place)  Memorial Cem. 11/30	118 20	c. Location - City or	Town, State
Balti	permit. Departm Importe any infu		21. Signature of Funeral Service Licenses	22 Name and Address of Facility Hardesty Funeral H 12 Ridgely Avenue,	ome, P.A		
8760,	Physician /Medical Examiner	ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to airmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of d.	Cauco ):	respiratory arrest		Approximate interval Between Onsevand Death
Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Ne 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year
rds, P.O.	w requires that the been signed by should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	1	. /	the cause of death?
Vital Records,	ysician: The law re is certificate has bee director, page 2 sho	e Completed	25. Was case referred to medical	26. Place of Death (	24a. Was an autopsy performed 1 Yes 2	d? prior to death?	topsy findings available completion of cause of
	Physici this cer al direc	To B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outs			e 6 Other (Spec	eify)
ono	ding l	tion:	27. Manner of Death  Adural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury  28b. Till (Month, Day Year)	me of 28c. Injury at 28 work?  M 1 ☐ Yes 2 ☐ No	3d. Describe how	injury occurred	
Division of	in line	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office 28	3f. Location (Stree City or Town, S	et and Number or Ru State)	iral Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dii completely filled in	edical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, an for investigation, in my opinion, death occurred	nd due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
)	To t with To t	2	29b. Signature and title of courtier	29c. License number  P (P fo	_	Date signed (Month	Day, Years
	10		30. Name and address of person who completed cause of death (Item 23a) (Tharles J. Wu, M.D. 1600 S. Crain		urnie, M	16 210	61
	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 1 2004  32. Registrar's Signature	South			

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of F			iene eg. ip2. N. N. I.	27000										
			Decedent's Name (First, Middle, Last	)				2. Date of Deat		3. Time of Death										
	Physici /Medio		Joethel		Gi	bson	Month 11	6:a M												
	Examir		4a. Facility Name (If not institution, give	street and number)			r Location of Death		4c. County of De											
			Lorien N.H. Fran				imore		NA											
	Funeral Director		5. Social Security Number 6. Se 10 10 10 10 10 10 10 10 10 10 10 10 10	TM of YE	e (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8–14-	, Year) (	irthplace (State or Foreign Country)  Md.										
	pu 🛊		Usual Residence of Decedent  10a. State 10b. County	·	10c. City, Town or Lo	ncation				10d. Inside City Limits										
	Aarylis f sho	ō	Md. NA		Balti					1X Yes 2 □ No										
	the 1	Director	10e. Street and Number		Darci	10f. Zip Code		1	Country?											
	3a or		3200 Elmora Ave			21213			USA											
36	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural" or items 23a or 28a-f show event, the Medical Eventher must be rectified at	by Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give X	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	tispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: B	ite, etc.										
21215-0036	hour turai		3 Widowed 4 □ Divorced  15. Decedent's Edu	Year or Dates:	16a Dece	dent's Usual Occup	ation		16b. Kind of Busines											
7.5	in 72 n "nat	Completed	(Specify only highest grad	e completed)	(Give	kind of work done	during most of work	ring	TOD. KING OF BUSINES	silidustry										
212	illed within Hygiene. other than "	E O	Elementary/Secondary (0-12)	College (1-4or 5		Orderer	Packer		Perfect G	arment Co.										
	be filed stal Hygi d other event, I	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M												
Maryland		2	Frank 19a. Informant's Name/Relationship (Ty		ngram	and Address (Street	Elve		Tys , City or Town, State,											
Ma	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		Myron Harris	Son	1	_	Ave., Ba			213										
Baltimore,	ges 1 and 3 t of Health if item 27 or other tr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other place	сө)	Date	20c. Location - City o	r Town, State										
ij	t. Partmen tant: njury		'4 Donation 5 ☐ Other (Specify)		Parkwood			0-04	Baltimore	, Md.										
Ba	permit. Pages. Department of the important: if ite any injury or of once.		21. Signature of Funeral Service Licens	" w a	ne 2	March F.	,	110	ltimore, M	id, 21202 i Ave.										
	Pnysician /Medical Examiner	ner	her	ner	ner	ner	ner	ner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or as:	a consequence of):		ceiden			Approximate Interval Between Onset and Death				
	cate be executed physician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):																
8760,	cate be ex physician the buria	dlcal E		a Carcinome of the break																
687	ificate g phy: as the	edic																		
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	by	by Physician/Me	ysiclan/M	ysiclan/M	ysiclan/M	ysiclan/M	ysiclan/M	ysiclan/M	ysiclan/M	ysiclan/M	ysiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)  9 Unknown						
<u>α</u>	signed by d be detac			Part II. Dther significant conditions con	ntributing to death bu	ut not resulting in the u	nderlying cause give	en in Part I.			to the cause of death?									
Records,	w requir been s should	lete						24a. Was ar	24h Were a	utopsy findings available										
I Re		Completed						autopsy	prior to death?	completion of cause of										
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	la a sia la			26. Place of Deat	h (Check only one	9)											
of	Phys this al dii	٩	Tes Zeno		nt 2 ER/Outpatien v 28b. Time of		4 1 Tursing Ho		nce 6 Other (Spe	ecify)										
L C	ling After fune	lon	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injur (Month, Day	Year) 280. Title of Injury	Worl	Yat k? Yes 2 □ No	28d. Describe ho	w injury occurred											
Division	Attending r death. ector: After by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, farm, stre			28f. Location (Str	eet and Number or R	lural Route Number,										
Ω	ai or after after Dire d in b	erti	4 Homicide	building, etc	c. (Specify)			City or Town	, State)											
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Physical Check only one)	ner: On the basis of	of my knowledge, death examination and/or inv	occurred at the time vestigation, in my of	ne, date and place, pinion, death occurr	and due to the ca red at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)										
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner sta		29c. License	e number	29	d. Date signed (Mon	th, Day, Year)										
)	-3-8		· parto	No.	MD	DI	51464		11/29/	04										
0	16		30. Name and address of person who co	impleted cause of de	eath (Item 23a) (Type,	Print)	1	0.	6 2 -	S. C 12 0.										
Y	) ('	1,41	SHOAIRS A. H	APITM	My)	821 1	J. Enla	w st	Inte -	30 F Balt.										
	Sta Registr	- 4	31. Date filed ( <i>Month</i> , <i>Day</i> , <i>Year</i> )  BEC 0 1 2004		ar's Signature	Sparker	7			1.10 210										

Amend item#12, perfit, 6838, 12/6/04 11 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** wing /Medical 4a. Facility Name Unot institution, give stre 4b. City, Town, or Location of Death 4c. County of Death Examiner ilitation Exended Care 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**X** M 2□ F 86 218-01-4610 Director 25 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28e-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic evant, the Madical Examities must be mailited at Director XXYes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6407 Western Run Drive U.S.A. 21215 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify 3 ☐ Widowed 4 🛣 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Waiter na Stevenson Caterer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benkley Gordon Sarah Fellman ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6407 Western Run Dr., Balto, Md Gloria Burton-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 11/24/04 Owings Mills, Md 22. Name and Address of Facility
March F/H West
4300 wabash Ave, Baltimore, Md 21. Signature of Funeral Service Licensee 21215 Port 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Cher (specify) 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rmed? 2 A No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospitei or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To : After this tuneral dir 27. Manner of Death 1 Natural 2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No in by the Director: 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ted cause of death (Item 23a) (Type, Print) AUGUSTIN Ch 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

**Physic** /Medi Examir

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mantel Hygiene. Important: If item 27 is marked other than "natural", or heme 23a or 28a-f ahow any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

	Ple	ase Type o	or Print in	Black Ir	ndelible In	k. Assı	ure A	II Cople	s Are I	_egib	le.			
			e of Marylar	and / Depa		f Health a	and M			104	37892			
1. Decedent's Nar	me (First, Midd	lle, Last)						2. Dete of De	Death		3. Time of Death			
Brooklyn	nn Lee	Goodman					,	Nov En	ber 2		1345 PM			
		on, give street and	i number)			4b. City, To		ocation of Deat		County of	,			
		tal of		mark		Balti	imo	1-4						
5. Social Security		6. Sex		rs. lest birthdey)	/) If Under 1 Yes	ear If Under 2	r 24 Hrs.		dirth	n/a	9. Birthplece (State or Foreign			
none	,	1□ M 21 F		Yrs.	Months Day 22	ys Hours	Min.	NOV.	Day, Year) 6, 200		Country) Maryland			
Usuel Residence	of Decedent							1100.	J, 200	/4	ат утапа			
10a. Stete	10b. County	/	10c. C	City, Town or Lo	.ocation						10d. inside City Limits			
Md.	n	ı/a		Palti							1√2 Yes 2 □ No			
10e. Street end Nu		/a	Baltimore 101. Zip Code 10g. Citizen of							en of Wh	nat Country?			
		Dood						}						
4237 Flo			Decedent Ever in U	110 13		229 of Hispanic Orio	1-1-2 /Sr	14. Vac or h	- 1		USA - American Indian,			
11. Marital Status		Armed	d Forces?	اري.	. Was Decedent of If Yes, specify Cu	uban, Mexican	i, Puerto	Rican, etc.)	0-		- American Indian, , White, etc.			
1 1	arried 2□ Marr d 4□Divorced	If Yes,	es 2 No i, Give X		1 ☐ Yes 2 🔀 N	No Specify:	2		5	Specify:	Black			
3 LI VVICONOC			or Dates:	10= Door		11			125 Kie	12:10				
(Sp		nt's Education est grede complete	ed)	(Give	edent's Usual Occ e kind of work don DO NOT use retii	ne during most	it of work	cing	16D. NIIIU	16b. Kind of Business/Industry				
Elementery/Sec			ge (1-4or 5+)			190)								
0			0	r	none	10 Moth	* Mam	om - A Midd	********	none				
17. Fether's Neme								ne (First, Middle						
Darnell	L. Good	dman				Las	Shan	dra S.	Powel	<u>.1</u>				
19a. Informant's N					ling Address (Street				-					
Darnell	L. Goor	dman / fa					d, B	altimo	re, Ma	ıryla	and 21229			
20a. Method of Dis	Disposition		20b. I	. Place of Dispo	oosition (Name of ematory or other p			Date	_		tity or Town, State			
1 ☐ Burial ≥ 4 ☐ Donation	2 ☐ Cremation ☐ Other (€	3 □Removal from Specify)	m State B		Cremato	-	1	1/24/0/	Balt	rimor	re, Maryland			
21. Signature of F				_		-					ome, Inc.			
11.	0 /	47.	Λ,								aryland 21229			
- Spe	-X-wi	200	wer							• • • • • • • • • • • • • • • • • • • •				
23a. Part1. Enter shock, or he	the disease, or eart failure. List	or complications that it only one cause or	at caused the dear on each line.	ath. Do not end	ter the mode or up	ying, such as	cardiac o	or respiratory e	∌rrest,		Approximate Interval Between Onset and Death			
											Onset and Death			
Immediate Cause	ition	. 56	nsis								7 day:			
resulting in deeth)	)	e. ——/	Due to /	(or as a conse	quence of):						1			
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Sequentially list of	conditions.	6	Due to /	or as a conse	ruence of):	7								
if any, leading to it cause. Enter Und	immediate derlying				,						1			
Cause (Disease of that initiated event	or injury nts	C	Due to /	(or as a consequ	cuence of):									
resulting in death)			Du	of as a conseq	uence or <sub>j</sub> .									
ı .	,	d												
- Cat alar	1	* Proting t	The set se	- that		* Post !		COL Div			and south			
Part II. Other sign	ificant conunio	ions contributing to	) death but not re-	sulting in the u	nderlying cause ;	jiven in Part i.			_		ribute to the cause of death			
								10	Yes 2	No 3[	3 ☐ Probably   4 ☐ Unknow			
								242 We	tonr		Ware autoney findings			
i									s an autopsy formed?	4 ~	24b. Were autopsy findings available prior to completion of cause			
											of death?			
<u> </u>								217	Yes 2	No	1 ☐ Yes 2 ☐ No			
25. Was case refe	erred to medica	4				26. Place	e of Deat	th (Check only o	one)					
examiner?	≫(No	Hospital:	npatient 2	☐ ER/Outpatien	ent 3 DOA	Other:		ome 5□Resi		□Other	(Specify)			
27. Menner of Dea	ath	28a. Det	ete of Injury	28b. Time of				28d. Describe						
1 Naturel	5 Pendin investig	ing (Ma	Month, Dey Year)	Injury		Vonk? □Yes 2□N								
3 ☐ Suicide	6 Could r	not be 28e. Ple	lece of Injury - At h	home, farm, st				28f. Location	(Street and	Number	or Rurel Route Number,			
4 ☐ Homicide	_ determ	illined	uilding etc. (Specif	2011e, raini, c	001, 14010-7, 01	3	1.0	City or Tr	own. Stete)	V60112-	J. 110101.110010			

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriet-trensit Division of Vital Records, P.O. Box 68760,

State Registrar

Medical Cer

29a. Certifier (Check only one)

29b. Signature end title of certifie

Catherine Part 31. Date filed (Month, Dey, Year) DEC 0 1 2004

Partyka,

32. Registrer's Signature

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

MD

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. License number 00052144

2401 W. BEIVEDERE AVE.

29d. Date signed (Month, Day, Year)

November 22, 2004

Baltimork,

md 21215

Sinai Hospital

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No UU 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Da **Physician** EVELYN TERESA GRISWOLD NOVEMBER 29, 2004 4:35 PM /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner WESTMINSTER NURSING/REHABILITATION CENTER WESTMINSTER CARROLL 8. Date of Birth Month, Day JUNE 14, 1914 If Under 24 Hrs. 7. Age (In yrs. lest birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Deys Hours 1□ M 2√√ MARYLAND 90 Director 213-2**4-**3857 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene.
Important: If item 27 is marked other than "natural" ---any injury or other treumatic ex----10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director CARROLL WESTMINSTER MARYLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 21157 1234 WASHINGTON ROAD Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 20 No ff Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: Specify: 3 XVidowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) DOMESTIC HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) MARY ANNA JENKINS JOHN ALLEN WENK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20628 MARY ANN REED/GRANDDAUGHTER 49722 CEDAR LANE, DAMERON, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE NAT'L CEMETERY 12/3/2004 BALTIMORE MARYLAND 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee WESTMINSTER, MARYLAND 91 WILLIS STREET, . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner buriel-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (orla s e consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medicai Due to (or as e consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1\_Yas 2ENO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: ို 1 Yes 2 ₩6 2 ER/Outpatient 3 DOA 4□ Nursing Home 5□ Residence 6 □Other (Specify) this within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Naturel 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D25443

Registrar

State

JOHN W.

31. Date filed (Month

Jacks

688C POOLE ROAD,

WESTMINSTER, MD

d address of person who completed cause of deeth (Item 23e) (Type, Print)

32/Registrer's Signature

MIDDLETON M.D.

			For State Registrar	Sta	ate of M	aryland		artmen			and M	lental l		ne N201	11.	379	01.					
			Decedent's Name (First, Middle,	Last)								2. Date of			7 4	3. Time of [	Death					
	Physici /Medio		John Joseph	Hal.	lameye:	r, Sr						Nov.	28,	<sup>Day</sup> 2004	Year	2:00	РМ					
	Examin		4a. Facility Name (If not institution,					4b. City,	Town, or	Location of	of Death			4c. County	of Death							
			Brightview Assi					1	te Ma					Balt								
	Funeral		5. Social Security Number 215–03–7320	S. Sex	7. Ag 2□ F	85 (In yrs. 18	as <i>t birthday)</i> Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of (Month)	Day, Y	ear)	9. Birthp	lace (State or try)	Foreign					
	Director		Usual Residence of Decedent			00		<u> </u>				Dec.	4,	1918	Mai	yland						
	yland		10a. State 10b. County			10c. City	, Town or Lo	cation							1	0d. Inside City						
	e Ma	ctor	MD Balt	Lmore			Parkvi	lle								1 🗌 Yes	2 XNo					
	or 26	Funeral Director	10e. Street and Number					10f. Zip					10g	. Citizen of V	Vhat Cour	itry?						
	ath w	rai	8348 Ridgely O						234		1 1 11		_	ited 9								
	item item	nue	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie	12. W	as Decedent med Forces? XYes 2 -	Everin U.S	5. 13.	Was Deced	lent of Hi	spanic Ori n, Mexican	gin? (Spi n. Puerto	ecify Yes or Rican, etc.	No-		k, White,	an Indian, etc.						
936	urs af	by	3 ☑ Widowed 4 ☐ Divorced	lf.	Yes, Give ear or Dates:	140		1 ☐ Yes 2	No 🔀	Specify:				Specify	։ և	hite						
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene.  do other than "natural", or itams 23e or 28e-f ehow event, I're Medical Erarili at must be notified at	Completed	15. Decedent's (Specify only highest				16a. Dece (Give life.	dent's Usua	I Occupa	ation	t of work	ina	16	b. Kind of Bu	siness/In	dustry						
2	C 39	nple	Elementary/Secondary (0-12)		ollege (1-4or !	5+)						ii i g										
12	filed withle Hygiene. other then		17. Father's Name (First, Middle, L.		2		Hal	/ertis	si <b>n</b> g			- /Fine Adia		Catho]		eview						
and	should be filed withle nd Mental Hygiene. marked other than imatic event, the M	To Be	Joseph W. Hall:		r					Kath				nderki								
Maryland		F	19a. Informant's Name/Relationshi	(Type, Pi	rint)		19b. Mailir	ng Address	(Street a	and Numbe	or or Rura	al Route Nu	mber, C	ity or Town,	State, Zip	Code)						
	9 = 2 -		Pat Fitch/daugh	ter			8348	Ridge	elv C	Jak_Ro	oad	Park	vill	e, MD,	21	234						
ore	0 0		20a. Method of Disposition 1 □ Surial 2 □ Cremation	Remov	al from State	Ce	ace of Dispo emetery, crei	nsition (Name at or or or or	ne of ther place	в)	12/	Date 02/200	74 20	c. Location -	City or To							
Ë	Pages tment of I tant: if it		'4 □ Donation 5 □ Other (Spe	city)		Du.	laney				rdns	•		Timoni	Lum,	MD.						
Bal	20a. Method of Disposition    20a									n Fune 21 204		Home, 1	Inc.									
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	/Medical Examiner		resulting in death)		Due to (or as			10	1	111.	00	6			-	75	411.					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. —	Due to (or as a consequence of):											-43						
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9 X	The law requires that the death certitic tle has been signed by the ettending p page 2 should be detached for use as:	Physician/Me	IF FEMALE:	23c. If	yes, outcome	of pregnar	ncv				-		-	22d Day	a of dollars		-					
Вох	death etter	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1(	Live birth Pregnant at	2 Fetal	death 3		Ectopic pregnancy Other (specify)					23d. Date of delivery  Month Day Y			ear ear					
0	at the de by the stached	hys	9 Unknown	9[	Unknown																	
S, P	es tha igned be det			by P				Part II. Other significant condition	s contribut	ing to death b	ut not resu	Iting in the u	nderlying ca	ause give	n in Part I.		23e. D	id tobac	co use contr	ibute to th	e cause of dea	ath?
of Vital Records,	w require been si should I											1	☐ Yes	2 No	3 Prob	ably <del>†</del> ⊡Un	iknown					
ec	e law r has be	Completed											utopsy	Р	rior to cor	osy findings av	/ailable use of					
a F												1 □ Ye	s 2		eath?	2□ No						
Z.		Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ Ho	Hospita	al:	W			Othe			(Check on		<b>. . . .</b>	Ass	isted						
of		To tr	27. Manner of Death	288	a. Date of Inju	ry	ER/Outpatier 28b. Time of		Bc. Injury Work					njury occurre		Living	}					
ion	nding Path. r: Atter e funer	atio	1. ☐Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	(Month, Da	y Year)	Injury	М		? /es 2 □ 1	No											
Division	or Attend efter death Director: /	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		Place of Inj	ury - At hor	me, farm, str	eet, factory	, office			28f. Locatio City or	n (Stree Town, S	t and Numbe	or Or Rura	Route Numbe	er.					
	spital or ours efte seral Dir tilled in																					
	To the Hospital or Attending within 24 hours effect death. To the Funeral Director: Attencompletely tilled in by the funer	Medical	29a. Certifier  (Check only one)  1 Certifying 2 Medical E	caminer: C	: To the best on the basis of nd manner sta	fexaminati	vledge, deatl ion and/or in	n occurred a vestigation,	at the tim in my op	e, date and sinion, deat	d place, a	and due to t ed at the tin	he caus ne, date	e(s) and mar and place, a	ner as st nd due to	ated. the cause(s)						
	with.	Σ	29b. Signature and title of certifier					29c.	License	number	- 1		29d.	Date signed	(Month, I	Day, Year)						
,	21)		ye all	-					176	rra.	0/			11-2	ے۔ کر	24						
2	TX			no complet	5601	100	23а) (Туре,	Print)	31	2,5	Bu	NHI	une	CMV,	21	239						
	Sta Registr	_	31. Date filed (Month, Day, Year) DEC 0 1	004	32. Registr	ar's Signati	ure &	Spo	uks	1												

	4. 20 g		101	artment of Health and Me		ene	27005			
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death			
	Physici /Medic		Stella Carolin Ichniowski		November		7:50 A.M			
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death				
	<u> </u>		Ivy Hall Nursing Home	Middle River  If Under 1 Year   If Under 24 Hrs.	D. D. A. C. P. W.	Baltimore				
	Funeral Director		5. Social Security Number  6. Sex  1 M 2 V F  7. Age (In yrs. last birthday)  Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yo	(ear) 9. Birthpt	ace (State or Foreign			
			212-09-7602 93 Trs. Usual Residence of Decedent		August 4,	1911   Pola	and			
	rylan	_	10a. State 10b. County 10c. City, Town or L			10	Od. fnside City Limits			
	ith the Marylan or 28a-f show	cto	Maryland Baltimore Baltimor				1 ☐ Yes 2 X No			
	with th	Dire	10e. Street and Number	10f. Zip Code 21222	. Citizen of What Count United Stat	-				
	within 72 hours after death with the Maryland ene. than "netural", or items 23e or 28e-f show to Modical Examiner must be notified at	Funeral Director	6900 Broening Road  11. Marital Status 12. Was Decedent Ever in U.S. 13.			14. Race - America				
<b>'</b> 0	r iten	Fun	Armed Forces?  1 Never Married 2 Married I Yes 2 No II Yes, Give	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	ican, etc.)	Bfack, White, e	etc.			
9	ours a	by	3 XWidowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 XNo Specify:		Specify: Whi	Specify: White			
2	72 h	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv.	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	161	b. Kind of Business/Ind	ustry			
12	within ane. than	mpi	Elementary/Secondary (0-12)   College (1-4or 5+)	maker		Own Home				
9	filed Hygie othar ant, II	Co	8 0 HOME	18. Mother's Name						
Maryland 21215-0036	should be and Mental smarked o	To Be	Nicholas Mackowski	Sabina	Sasadeu					
	and 2 sh ealth and n 27 is m			ng Address (Street and Number or Rural Broening Road, Ba			Code)			
Baltimore,	Pages 1 and nent of He int: If itam		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposition cemetery, cre + Holy Ros	osition (Name of matory or other place) ary Cemetery  2004	per 2	c. Location - City or Tov undalk, MD	wn, State			
Baltii	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryla Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "netural", or items 23e or 28a-f show any injury or other traumatic evant, it a Modical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility endon Funeral Home 818 East Baltimore			MD 21224			
			23a. Part1. Enter the disease, or complications that caused the death. Do not er				Approximate			
b	Pnysician i		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	CANCER			Interval Between Onset and Death			
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	- one con						
В	Examiner		. Sequentially list conditions. b.							
	ba tis	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
	cate be executed physician and the burial-transit	Examine	resulting in death) Last  Due to (or as a consequence of):							
8760,	icate be ex physician s the buria	dicai E								
687	ificate g phy: as the	edic	0.							
Вох	leath certifica attending ph for use as th	In/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of deliver	*			
	e deat he att	Physician/Me	in the past 12 months?  1 Yes 2 No  4 Pregnant at time of death 5	Other (specify)		Month I	th Day Year			
P. 0	that the de led by the a detached t	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	andert in a course source in Dard I	23a Did tobac	and use contribute to the	a square of death?			
Records,	sign sign d be	ed by	FAITH, Other Significant conditions continuing to death out not resouring in the	inderlying cause given in rait i.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow					
000	e faw requ has been ge 2 shoult	Completed			24a. Was an autopsy		sy findings available			
Œ		Som			performed 1 ☐ Yes 2	d? death?	2□ No			
Vital	iician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)					
	this c	L <sub>o</sub>	1   Yes 2 No   Hospital: 1   Inpatient 2   ER/Outpatie			e 6 □Other (Specify)				
nc On	tending Physician: The leath.  Tor: After this certificate he the funeral director, page	ion:	27. Manner of Death  1	f 28c. Injury at 28 Work? M 1 ☐ Yes 2 ☐ No	d. Describe how i	injury occurred				
Division of	# 0 0 ×	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st		Bf. Location (Stree	et and Number or Rural	Route Number,			
á	at or A s after it Dirac	erti	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	State)				
	To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by	edicai C	29a. Certifier (Check only 2   Medical Examiner: On the pasis of examination and/or in	h occurred at the time, date and place, an	d due to the caus	se(s) and manner as sta	ited.			
	thin 24 thin 24 tha F mplete	Medi	and mahner stated.	29c. License number		Date signed (Month, D				
1	S 5 5 5	y	29b. Signature and title of certifier	D 38033	_	1/29/1	y, (ear)			
1	1 10		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) 1 /	0	- 1	/			
1	11		1. 715 ANN 12. 761 C. 1	hydayd hor	(SMC)	T. M)	21224			
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 1 2004		(					

			For State	State of Maryla		ent of Health and ate of Death	, ,	ene . No 2 n n l	07006	
	Physici	an	1. Decedent's Name (First, Middle, Last)	- M	JONE		2. Date of Death Month	Day Year	3. Time of Death	
	/Medic Examin		Social Security Number	DEPTIAL CE	4b. Ci	ty, Town, or Location of Deal	STOCON  B. Date of Birth (Month, Day, Y	4c. County of Death  AC. County of Death  AC. County of Death  Gear)  9. Birth  County of Death	TMOLE  splace (State or Foreign intry)	
	Director Mou		Usual Residence of Decedent  10a. State  10b. County	10c. C	City, Town or Location		NOU. 19	1727 3	10d. Inside City Limits	
	r 28a-f s	Director	10e. Street and Number	7		IMORE (	100	g. Citizen of What Co	1₽Yes 2□No untry?	
	ath with	ralD		WS FALL		21216		USA		
5-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28a-f show Its Modical Examilier mat be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ② No If Yes, Give Year or Dates:	ff Yes, s	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer 2 PNo Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify:		
1215-0	within 72 hours ene. than "naturel", the Worlest Ex.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> Colfege (1-4or 5+)	life. DO NOT	work done during most of wo	orking	Sb. Kind of Business/I	ndustry	
and 2	be filed tal Hygi d other event, t	To Be Co	17. Father's Name (First, Middle, Last)	SMITT			me (First, Middle, Ma	niden Surname)	155 155	
Maryland	and 2 should ealth and Men n 27 Is marke ler traumatic	-	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailing Addre	ess (Street and Number or R	ural Route Number, C	City or Town, State, Z	ip Code) 19131	
Baltimore,	0 0 = =		20a. Method of Disposition  1	emoval from State	Place of Disposition (//	lame of rother place)	Date 20	C. Location - City or	Town, State	
Balti	permit. Pag Department Importent: I eny injury o once.		21. Signature of Funeral Service License		22. Name	MEM PK // and Address of Facility A		FUNERAL BACTO, 1	HOME ND 21207	
	Physician		23a. Part. Enter the disease, or complishock or hearfailure. List only or Immediate Cause (Final disease or condition		ath. Do not enter the m	ode of dying, such as cardia	c or respiratory arres	t,	Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a conse			-			
-	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.						
8760	icate be ex physician s the burial	dicai		1						
O. Box 6	attending for use a	ysician/Med	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	ital death 3 □Ectopic	pregnancy (specify)		23d. Date of deli	very Day Year
rds, P.O.	quires that the de n signed by the ald be detached	b		tions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the remainded of the contribute to the contribution of the cont						
of Vital Records,	The law requirate has been single 2 should	Completed	chuanic dost	metive jun	is disease		24a. Was an autopsy performe	d2 prior to c	topsy findings available ompletion of cause of	
/ita	Physicien: The this certificate ral director, page	Be	25. Was case referred to medicaf examiner?	lospitaf: 🙏		Othor	ath (Check only one)			
on of \	Phys r this ral di	tion: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)				ce 6 ☐Other (Specinjury occurred	ify)	
Division	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, fact cify)	tory, office		Location (Street and Number or Rural Route Number, City or Town, State)		
	To the Hospitel or A within 24 hours after To the Funerel Directompletely filled in by	Medical C	29a. Certifying Physical Control (Check only one)	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death occurr nation and/or investigat	ed at the time, date and plaction, in my opinion, death occ	e, and due to the cau urred at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)	
	To the To the comp	N N	26b. Signature and title of certifier	6		29c. License number		Date signed (Month		
<b>7</b>	11		30. Name and address of person who co	mpleted cause of death (Ite	em 23a) (Type, Print)	Maryin Me		ovember 2	23, 2009	
7	U			Road Ran	dallstown	manyjay me	21133			
	Sta Regist		J. Date lines (MODELEY, Ual 20	04 32. Redistrar's Sig	D A	parks				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Vo Vember2 3:00 AW 72004 /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) Examiner Baltimore Mom Hours Min. July 21, 1905 If Under 1 9. Birthplace (State or Foreign Country) Mary land 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2\F 99 216-07-1254 Yrs. Director Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours aftar death with the Marylend Depertment of Haalth and Mantal Hygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🗷 No **Funeral Director** MD Parkville Baltimore 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 8710 Emge Road 21234 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: Specify: Be Completed by white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Sales Retail 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James W. Koller Elva G. Bennett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Douglas Hiob nephew 727 High Plain Drive; Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Wesley-Freedom Methodist Cem. 11/30/04 Eldersburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service License 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home 23a. Pert1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause/or each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical minute Examiner Due to (or as e conseque Physician/Medicai Examiner signed by the attending physician end Id be detached for use es the bunel-trensit or Attending Physician: The law requires that the death certificate ba axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? ours after death. Insel Director: After this certificata has been si filled in by tha funerel director, page 2 should I 24a. Was an autopsy performed? DV85167 1 Yes 2LUNO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Hospital: Medicai Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Dey Year) 27. Mannet of Death 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 UNatural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funerst D completaly filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number (zui ed cause of death (Item 23a) (Type, Print) 60 0 31. Date filed (Month, Day, Year) State Registrar

	•	1- State of Maryland / De Registrar	partment of Health and ertificate of Death		giene 0 0 4 3 7 8 9 8
Physicia /Medica		1. Decedent's Name (First, Middle, Last)  Johnnie Peter King		2. Date of De Month	Day Year 3. Time of Death 1:30 p M
Examine		4a. Facility Name (If not institution, give street and number) 2909 Georgia Avenue	4b. City, Town, or Location of Dea  Baltimore  y) If Under 1 Year   If Under 24 Hr		4c. County of Death Baltimore
Funeral Director		5. Social Security Number  511-50-9442  Usual Residence of Decedent  6. Sex  1 Am 2 F  7. Age (In yrs. last birthda 2 F)  7. Age (In yrs. last birthda 2 F)  7. Age (In yrs. last birthda 2 F)  7. Age (In yrs. last birthda 2 F)  7. Age (In yrs. last birthda 2 F)  7. Age (In yrs. last birthda 2 F)	Months Days Hours Mir		9. Birtholace (State or Foreign Country) 11, 1947 West Virginia
death with the Maryland ms 23a or 28a-f show rraust be notified at	ctor	10a. State     10b. County     10c. City, Town or       Maryland     Baltimore     Baltimore	re		10d. Inside City Limits 1 ☐ Yes 2☐ No
th with th	Funeral Director	10e. Street and Number 2909 Georgia Avenue	10f. Zip Code 21 227		10g. Citizen of What Country? USA
Urs after ali, or Ite	۵	11. Marital Status  1. Marital Status  1. Was Decedent Ever in U.S. Armed Forces?  1. Mare Forces?  1. Marital Status  1. Was Decedent Ever in U.S. Armed Forces?  1. Marital Status  1. Was Decedent Ever in U.S. Armed Forces?  1. Marital Status	3. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue  1 ☐ Yes 2 ▼ No Specify:	Specify Yes or No rto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.  Specify: White
within son.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of w b. DO NOT use retired) collection Manager	-	16b. Kind of Business/Industry  Health Care
trad Hyber file of the evant	To Be Co	17. Father's Name (First, Middle, Last) PaUL Leo King	18. Mother's Na		, Maiden Surname)
	1		illing Address (Street and Number or F 9 Georgia Avenue,		er, City or Town, State, Zip Code) re, Maryland 21227
altimore, M rmit. Pages 1 and 2 partment of Health portent: if item 27 y injury or other tr.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	position (Name of rematory or other place)	Date /29/04	20c. Location - City or Town, State  Baltimore, Maryland
Baltimore permit. Pages 1 Department of H important: if its any injury or ot		21. Signature of Funaral Service Licenses	22. Name and Address of Facility H	ubbard F	uneral Home, Inc. imore, Maryland 21229
Physician		23a. Part1. Ever the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)			rrest, Approximate Interval Between Onset and Death
Medical Examiner whysician and the burial-transit in the burial-tr	Ilcal Examiner	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	nal aneuvsl extrusion		
<b>ω</b> ≅ ⊑ ∞	Physician/Med		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
Cords, P	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did t	tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
	Completed			24a. Was auto perio 1 Yes	
f Vita ysician: is certific director.	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Other	eath <i>(Check only o</i> Home 5 ➤ Resi	idence 6 Other (Specify)
Division of Vita i or Attanding Physician: after death. Director: After this certification by the funeral director.	ation: T	27. Manner of Death  1 X Natural 5 Pending (Month, Day Year)  2 Accident investigation 28a. Date of Injury (Month, Day Year)  28b. Time (Month, Day Year)	of 28c. Injury at		how injury occurred
Div	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location ( City or To	Street and Number or Rural Route Number, wn, State)
Ra Hospital	edical	29a. Certifier (Check only one)  2 Medicel Examiner: On the basis of examination and/or and manner stated.			
To that within 2 To that complete	M	≥ Watter Kengel NW	29c. License number		29d. Date signed (Month, Day, Year)
16		30. Name and address of person who completed cause of death (Item 23a) (Type Walter Koppel, MD 8501 LaSalle Ro		3	
Stat		31. Date filed (Month, Day, Year)  DEC 0 1 2004  32. Registrar's Signature	ad, Towson, Maryla	<del>ti IQ</del>	

1c, Edward A

			1 - For State Registrar	State of Ma	aryland		artment of H rtificate of I		d Mental Hy	/giene Reg. No. ()	n L	37899
			1. Decedent's Name (First, Middle, La	nst)					2. Date of D	eath Day	Year	3. Time of Death
	Physici /Media		EDWARDA. KALI	SZAK					11-2	7-04	1041	8,25 am
	Examir		4a. Facility Name (If not institution, gi				4b. City, Town, or	Location of D	eath	4c. Count	ty of Death	
			Franklin Sociare H	sotal Center	)		Roseda	le		Ba /	timore	
	Funeral				e (In yrs. las		If Under 1 Year Months Days	If Under 24 i	Hrs. 8. Date of Bi	rth ay, Year)	9. Birthr	place (State or Foreign
	Director		216-24-9672	TIM ZUF	76	Yrs.			7/10	728	MAR	YLAND
	and *		Usual Residence of Decedent  10a. State 10b. County	-	10c. City, 1	Town or Lo	cation					10d. Inside City Limits
	/anyl	ō	MD DAITT	MODE		77.0	CCEV					1 ☐ Yes 2 No
	the the 28a-	rect	MD BALTI	MOKE		E	SSEX 10f. Zip Code			10g. Citizen of	What Cou	ntrv?
	3a or	0	1100 SANDYSTON	E RD. APT	. C			1221		USA		
	ns 2:	Funeral Director	11. Marital Status	12. Was Decedent I		13. )			? (Specify Yes or No Lerto Rican, etc.)		ce - Americ	
0	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. and other than "natural", or Itams 23s or 28s-f show avant, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 SeYes 2 □ N	lo				lerto Hican, etc.)		ack, White,	etc.
200	nal', c	i by	3 Widowed 4 K Divorced	If Yes, Give Year or Dates:			1 □ Yes 2 🔼 No	Specify:		Speci	y: W	HITE
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ĕ	12 sh h and 7 ls m traum		19a. Informant's Name/Relationship MR. DANIEL KAL		- 3				Rural Route Numb	•		•
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pairimo	it. Purtune sirtani njur.)		' 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funer	ry)	DAI		CREMATO		/29/04 NERAL H	BALTII		, MD.
0	permit. Pages Department of the Important: If its any Injury or of once.			-					VE. BAL			. 21222
			23a. Part1. Enter the disease, or cor	nplications that caused	the death.						, 115	Approximate
١,			shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	1							Interval Between Onset and Death
•	nysician /Medical		disease or condition resulting in death)	a. Hy 00 0		MIG						
	Examiner			Sinsi	<	100 017.						
		Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequer	nce of):						
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00/0	icate be executed physician and s the burial-transit	dical		d. Prostate	Can	cer u	ith bone	Meta	Stasis			
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Š	ath ce ttendi or use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal de	eath 3	Ectopic pregnancy				ate of delive	ory Day Year
3	ie dec the a hed fo	Physician/M	1  Yes 2 No	4□Pregnant at 9□Unknown	time of deat	h 5∟	Other (specify)					
Ţ.	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as		Part II. Other significant conditions	contributing to death bu	ıt not resultir	ng in the ur	nderlying cause give	en in Part I	23e. Did	tobacco use con	itribute to th	ne cause of death?
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5	ding Phyaician: The h. h. After this certificate h. funeral director, page	H .	27. Manner of Death	28a. Date of Injur (Month, Day		VOutpatien 3b. Time of	28c. Injury Work	4   IAGISIII		how injury occur		r)
5	ding th: : Afte	tion	1 □Natural 5 □ Pending 2 □ Accident investigation		Year)	Injury		(? Yes 2 ☐ No				
VISION	Attar r dea actor by the	ifica	3 ☐ Suicide 6 ☐ Could not lead to determine determined	28e. Place of Inju	ry - At home	ə, farm, stre	eet, factory, office				ber or Rum	I Route Number,
5	s afte s afte s Dira	Certification:	4   Hornicide	building, etc	. (Зреспу)				City or To	wn, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (		hysicien: To the best of miner: On the basis of and manner sta	examination							
	o tha ithin : o the omple	Mec	29b. Signature and title of certifier	and mariner sta	)		29c. License	number		29d. Date signe	ed (Month,	Day, Year)
	<b>⊢ s ⊢</b> ō		De Mun	Hash			BIER	MANN		11-77	-04	
			30. Name and address of person who	completed cause of de	eath (Item 23	3a) (Type. I	Print)	00000		11/-1	7	
			Dr. Minus Vasi	19 Des 90	SOF	inkli	0	Drivo	Baltim	cre, Ma	1.712	37
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra 2004			1 4	W. ( V V		, , , , ,		
	Registr		DEC 0 1	2004	ne s	F A	MARINE !					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item#8,10a-f,16a,26, per Inf, MD, 6844,6727/05 TI State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 9:20 A.M Lewis 2004 /Medical <u>Margaret</u> November 24, 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 8508 Allenswood Road Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1928. Birthplace (State or Foreign Months | Days | Hours | Min. | Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 77 Yrs **Funeral** 181-26-3592 1 M 2 KF Months Yrs. Director Virginia Usual Residence of Decedent the Maryland ahow State 10b. County 10d. Inside City Limits PLTTSBURGH item 27 le marked other than "natural", or Items 23a or 28a-f abov other traumatic event, the Madical Examinar must be notified at ALLEGHENY PA Director 1 Yes 2 VINO -MD Baltimore 7309 SOMERSET ST 10e. Street and Number 10f. Zip Code 15235 10g. Citizen of What Country? death with 8508 Allenswood Road 21133 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Black 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7, th and Mental Hygiene.

7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) TEACHER ASSISTANT Education 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth Herdon S.Atwell Wills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health as Important: If item 27 le any injury or other trau once. 8508 Allenswood Road, Randallstown, Maryland 21133 Cynthia Evans Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Homewood Cemetery 11/29/04 Pittsburgh, PA. 15208 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors Inc hat Bulese 8728 Liberty Road, randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) eio myo sarcoma Physician /Medical Due to (or as a consequence of) Examiner LUN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine equires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed Sam 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has pression or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6X DAUGHTER'S RES. Hospital: 1 Yes 2 No 1 Inpatient ို 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Medical Certification; 5 Pending investigation 1 Natural thours after death. death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 296. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, MD 040867 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TREE Rd. BALTIMORE MD. 21203 SADOVNIK 1838 MIGUEL GREENE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 0 1 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrament TTEM #26 PER PHY C838 1996 if Gate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Da 30 DM **Physician** NOI 20 200 /Medical 4c. County of Death 4b. City. Town, or Location of Death **Examiner** IMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days -20-65 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Items 23a or 28a-f show injury or other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number Funeral 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Depertment of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or item finjury or other traumate. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 12 No Specify þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) In Known Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walters Kobert Mare Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTO 21202 CALVERT ST. BONNIE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11-29-04 Marylar ¹ 4 □ Donation 5 □ Other (Specify) trbutus Funeral Service Licensee 22. Name and Address of Facility Howell FUNERAL 21. Signatus MD 2/20 Enter the disease, or complications that caused the drath. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MONT /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical cate has been signed by the attending physi , page 2 should be detached for use as the I IF FEMALE: 23c. Il yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 Mo 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifics 26. Place of Death (Check only one) 25. Was case referred to medical Be ASSISTED examiner? Other: 4 Nursing Home Sessidence Compther (Specify IVING Hospital: 1 Inpatient 2 ER/Outpatient 1 ☐ Yes 2 No 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury oc 28b. Time of 28c. Injury at Work? 1 Natural 1 Yes 2 No investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Sign 29c. License number ure and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DEC 0.1 000

31. Date liled (Month, Day, Year)

MANUEZ V. PAMOS

32. Registrar's Signature

MD 5

State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / E	Certificate	of Death		Reg Roll	37902
	Dhysinis		Decedent's Name (First, Middle, Last)			2. Dete of E		3. Time of Death
	Physicia /Medic		EVELYN P. MULLER		1	11	-3c - Z	004 5:45 AM
	Examin	er	4a Fecility Name (If not institution, give street end number)		Parky	m, or Location of Dec	th 4c. County of Baltim	
_	F		Oak Crest Care Center  5. Social Security Number 6. Sex 7. Age (In yrs. lest birl	thdev) If Under 1 Y	rear If Under 2	4 Hrs. 8 Date of F		9. Birthplace (State or Foreign Country)
	Funeral Director		The offe	Yrs. Months D	Pays Hours	Min. (Month, I Nov 20	), 1924 P	'ennsylvania
	ylend		10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
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	ith with the Maryle 23s or 28s-f sho ust be notified at	Dire	10e. Street and Number	10f. Zip Co			10g. Citizen of Wh	et Country?
	s 23	Funeral Director	5 Morn Mist Court  11. Marital Status 12. Was Decedent Ever in U.S.	21234		in? (Specify Yes or N	USA Io- 14 Bace	- American Indian,
10	s efter des , or Nems	F	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No			in? (Specify Yes or N Puerto Rican, etc.)	Black,	White, etc.
036	ours eff sel', or Evann	þ	3 XWidowed 4 ☐ Divorced If Yes, Give Yeer or Dates:	1 □ Yes 2 □ X	(No Specify:		Specify:	white
5-0	72 ho	eted	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual O (Give kind of work d life. DO NOT use re	occupetion fone during most	of working	16b. Kind of Busi	ness/industry
121	filed within 72 hours efter death with the Marylend Hygiene. ther than "natural", or flems 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	Elementery/Secondary (0-12) College (1-4or 5+)	nemaker	etired)		Own Home	
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Baltimore, Maryland 21215-0036	pernit. Pages 1 and 2 should be filed within Department of Health end Mentel Hygiene. Important: If Item 27 is merked other than any injury or other traumatic event, the Modes.					or Rurel Route Num. Baltimore,		
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Division of Vital Records,	requires been sign should be	Completed by				24a. We	s en eutopsy formed?	24b. Were autopsy findings available prior to
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6	100		30. Name and edgress of person who completed cause of death (Item 23a) (		) Put	alle mo 2	1234	
1			Jcff Kandram no 6600 Wa  31. Date filed (Month, Dey, Year)  32. Registrer's Signeture	(4100 Die	10000	-(u 110		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 20, 2004 <u>Geraldine Patricia Moran</u> November /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Caroline 502 Strawberry Court Ridgely If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 5 F 66 Yrs. March 17,1938 Maryland Director <u>212-36-7057</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No Director Caroline Ridgely Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21660 USA 502 Strawberry Court e filed withIn 72 hours after deeth all Hygiene. I other then "natural", or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 55 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done du life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any liqury or other treumatic event 2008. Be Annie Martin Lawrence F. Thomason, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10906 Fleetwood Drive, Beltsville, MD 20705 Mary Ellen Whitcraft (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State Hillcrest Cemetery 11/24/2004 Annapolis, MD \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 00 disease or condition resulting in death) /Medical Examiner Isease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury been signed by the ettending physicien and should be detached for use as the burial-transit certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 25No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: After this c 1 Yes Certification: To 2 \ No 1 Innatient 2 □ ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 Pasidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident efter death 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funeral I completely filled Hospitel 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 295 Signature and title of celtif 29c. License number D14664 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Christian E.

31. Date filed (Month Day

Jensen,

32. Registrar's Signature

M.D., PO Box 690, Denton, Maryland 21629

			1 - For State Registrar		of Maryla	nd / Depa		t of H	ealth a	and M	lental Hy		004	37906
	Physici	on	1. Decedent's Name (First, Middle,				-				2. Date of De		Yeer	3. Time of Death
	Physici /Medi		Gabriel	Mench							NOVEMBE		2004	7:10P. M
	Examir	ner	4a. Facility Name (If not institution,		number)				Location	of Death		4c. Co	unty of Deat	
	<b></b>		3900 GREENMOUNT 5. Social Security Number	AVE 6. Sex	7. Age (In yrs	last hirthday)	BA If Under	LTIN 1 Year	IORE	24 Hrs.	8. Date of Bir	th	N/A	
	Funeral Director		349-62-3551 Usual Residence of Decedent	<b>Й</b> Д <b>Х</b> М 2□ F		Yrs.	Months	Days	Hours	Min.	Sept 3,	<sup>ÿ, </sup> 1964	I	thplace (State or Foreign buntry) Linois
	Maryland	tor	Maryland N/A		10c. C	ity, Town or Lo Baltime								10d. Inside City Limits XX Yes 2 □ No
	n with the	Funeral Director	10e. Street and Number 3900 Greenmount	Avenue			10f. Zip	Code 2121	8			10g. Citizen	of What Co	puntry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "neturel", or items 23e or 28e-f show important: if item 27 is marked other then "held is net real to a realified at any highly or other traumatic event, the Medical Examinal must be realified at ance.	by Funera	11. Marital Status  1 <b>∑X</b> Never Married 2☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed 1 □ Ye If Yes,	ecedent Ever in t Forces? s <b>2/X</b> No Give r Dates:		Was Deced f Yes, spec			igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)		Race - Ame Black, Whit ecify: Wh	
Maryland 21215-0036	filed within 72 ho Hygiene. rther then "netur ent, the Medical	Completed by	15. Decedent (Specify only highest Elementary/Secondary (0-12)	grade complete	d) 3 (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us Strone	k done d e retired	tion uring mos	t of work	ing	Spac	e Te	Industry lescope Institute
yland;	should be filed nd Mental Hygid marked other umatic event, I	To Be C	17. Father's Name (First, Middle, L Tomas Menchad						18. Mothe Rosa	er's Name L H∈	ernandez	Maiden Sui Z	mame)	
	1 and 2 sho Health and tem 27 is ma		19a. Informant's Name/Relationsh Alejandro Mencha		ther	1731	B1u	est	em L	ane	Glenv			
lore	Pages 1 nent of H ant: if iter ury or oth		20a. Method of Disposition 1 ☐ Burial ※ Cremation			Place of Dispo					Date			Town, State
Baltimore,	permit. Pag Department Important: I any injury o		*4 □Donation 5 □ Other (Sp 21. Signature of Europal Service L		D.	altimo Crema Bi	tory Name and urgee-	d Addres -Hen:	s of Facilit	itz	Funeral	Home	. Inc.	Maryland 21211
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P.O. Box 687	the death certific by the attending p ached for use as	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Liv	outcome of pregn e birth 2 ∐Feta gnant at time of d known	aldeath 3□	Ectopic pre					23d.	Date of deli Month	ivery Day Year
	w requires that been signed b should be det	by	Part II. Other significant condition	ns contributing to	death but not re	sulting in the ui	nderlying ca	use give	n in Part I.			obacco use d		the cause of death?
Vital Records,		Completed									24a. Was autop perfo		prior to death?	topsy findings available completion of cause of
Vita	9 G	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o			
of		tion: To	1 ⚠ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigs	28a. Da	Inpatient 2 te of Injury onth, Day Year)	28b. Time of Injury	28	Bc. Injury Work	4 LI NU		me 5 ☐ Residence 128d. Describe h	ow injury oc	curred	SELF
Division	Hospitel or Attending 24 hours after death. Funerel Director; Afte tely filled in by the fune	Certification:	3 Suicide 6 □ Could n 4 □ Homicide determin	ned 286. Pla	ice of Injury - At hilding, etc. (Speci			office			City or Tou	m, State)		ral Route Number,
	To the Hospitel of within 24 hours at To the Funerel Completely filled in	edical (	29a. Certifier 1 Certifying (Check only 2 Medicel E	xeminer: On the	he best of my know basis of examina anner stated.	owledge, death ation and/or inv	occurred a	at the time in my op	e, date and inion, deat	d place, a	and due to the o	cause(s) and date and plac	I manner as ce, and due	stated. to the cause(s)
)	To the within 2 To the complet	D	29b. Signature and title of certifier	,			29c.	License O.C.	number M.E.			29d. Date siç		
il	)1		30. Name and address of person w	no completed ca						t, B	altimor			
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 1	2004 32.	Registrar's Sign	ature	So	ak						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ng. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 28, Isabelle Η. McElroy November 2004 7:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Care Center at Oak Crest Village Baltimore Parkville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 213-16-5938 83 January 08,1921 Director Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or iteme 23a or 28e-f show or instraint be notified at 40 1 Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11/28 3819 Bay Drive 21220 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 XWidowed 4 □ Divorced 202 "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i 2 should be filed within 7: and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) M 0 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George D. Harman Elizabeth J. Loose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 a Department of Heelih ar Importent: If item 27 is eny injury or other treu once. 2201 Timber Lane, Finksburg, Maryland 21048 Thomas G. McElroy Sabelle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 12/01/04 Woodlawn, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors Inc 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Lewy Domento Bodu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours ofter death.

To the Funerel Director: After this c completely filled in by the funeral dire 1 Tes 2 No 2 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 🗀 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier morice 1) 58646 November, 29, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

souls?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200/00000

32. Registrar's Signature

walther

DEC 0 1 2004

31. Date filed (Month, Day, Year)

Monias

	1	For State Registrar	State of Maryland / Depa Cer	irtment of Health and M <i>tificate of Death</i>	Aental Hygie Reg.	ZHHE RIGHE
Physicia /Medica	n	Decedent's Name (First, Middle, Last)     TOHN		MC QUEEN	2. Date of Death Month NOVEMBER	Day Year 2 25, 2004 8 3. Time of Death
Examine	_	4a. Fecility Name (If not institution, give st		4b. City, Town, or Location of Death		4c. County of Death
		THE JOHNS HOPKIN		BALTIMORE CI	8. Date of Birth	NA  9. Birthplace (State or Foreign
Funeral Director		210 00 0 105 11	7. Age (In yrs. last birthday)  M 2 F	Months Days Hours Min.	8-24-5	ear) Country)
pup *	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation	+	10d. Inside City Limits
Maryli f sho	ō	Md Baltim	ore Essex			1 <b>X</b> Yes 2 ☐ No
r 28a-	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
h with	<u>a</u>	1012 Bayner Rd.		21221		USA
be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. Ad other than "natural", or iteme 23s or 28s-f show event, the Medical Exeminar must be rediffed at event, the Medical Exeminar must be rediffed at	by Funeral		1 🗆 Vac - 2 🖼 Vac	Vas Decedent of Hispanic Origin? (Sp I Yes, specify Cuban, Mexican, Puerto I □ Yes 2 No Specify:	pecify Yes or No- b Rican, etc.)	14. Race - American Indian, Black, White, etc. SpecifyBlack
2 hou	Completed	15. Decedent's Educ (Specify only highest grade		lent's Usual Occupation kind of work done during most of work		b. Kind of Business/Industry
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ld be fill ental H ked oth ic even	To Be	17. Father's Name (First, Middle, Last)  John	Luther McQueen			Mae Eden
s 1 and 2 should be f Health and Mental item 27 te marked o other traumatic ev	<b> </b>	19a. Informant's Name/Relationship (Type Denise McQueen Joh		ng Address (Street and Number or Rus 2 Bayner Rd., Esse	_	ity or Town, State, Zip Code) 21221
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ages nt of i t: # it / or o		1 🖾 Burial 2 ☐ Cremation 3 ☐ Re  1 ☐ Donation 5 ☐ Other (Specify)	emoval from State    Cometery, crem   King Mer	natory or other place)	2-04 F	Randallstown, Md.
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Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not enter e cause on each line.  CHRONIC LYMPHO  Due to (or as a consequence of):		or respiratory arrest	Approximate Interval Between Onset and Death  5 YEARS
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The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
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Fo the within Fo the comple	/Me	29b. Signature and title of certifier		29c. License number		. Date signed (Month, Dey, Year)
/-/	()	> 7 Nann	MD-PhD	VO288	NO	VEMBER 25, 2004
4/1		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, JOHNS HOPKINS HOSPI	Print) TAL 600 NORTH WOL	FE STREET	BALTIMORE MD 21287
V		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Souls		1

			For State Registrer	State o	of Marylar	nd / Depa <i>Cei</i>	artment o	f Health of Death	and M	lental Hy	giene Reg. No.	004	37907
	Physicia	an	Decedent's Name (First, Middle,     Tale and a second	, Last)						2. Date of De Month	eath Day	Yeer	3. Time of Death
	/Medic	al	Webster			Malon			(5 "	11	25	2004	8:45p M
	Examin	er	4a. Facility Name (If not institution, 1120 Darley Av	-	imber)			m, or Location Baltimo:			46. 00	ounty of Death	
	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ear If Unde	r 24 Hrs.	8. Date of Bi (Month, D	rth ,		place (State or Foreign
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	pu k		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Lo	ncation						10d. Inside City Limits
	Marylan f show	or	Md.	NA		•							1 X Yes 2 ☐ No
	rith the Man or 28e-1 sh	rect	10e. Street and Number	INA		Da.	ltimore 10f.ZipCoo				10g. Citize	n of What Cou	ntry?
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	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28e-1 show ent, the Medical Examination is calified at	Funerai Director	11. Marital Status	Armed F		J.S. 13.	Was Decedent If Yes, specify (	of Hispanic Or Cuban, Mexica	rigin? (Sp	ecify Yes or No Rican, etc.)	0- 14.	. Race - Americ Black, White,	
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45 altimore	Pages nent of I ant: If its ury or o		1 🔀 Burial 2 □ Cremation  '4 □ Donation 5 □ Other (Sp		State		Mem. P		12-1	-04	Arbu	itus, Mo	ā.
Ball	permit. Page Dep rtment of Important: If any njury or once.		21. Signature of Funeral Service L	icentee (			Name and Ad March F		•		imore, E. Nor	Md. 2 th Ave.	21202
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15ter Division	or Attendate death Director:	ertification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determ	200. Flac	e of Injury - At h ling, etc. (Speci	nome, farm, str ify)	reet, factory, off	fice		28f. Location ( City or To	'Street and h wn, State)	Number or Rum	al Route Number,
Nebs	spitel ours a serel D	O	29a. Certifier 1 Certifying	g Physician: To th	e best of my kn	owlodge, death	h occurred at it	le tima, date a	nd clacs.	and due to the	causais) ar	d marnet as s	lated.
K	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical	(Check only 2 Medical E	Examiner: On the I	basis of examination of stated.	ation and/or in	vestigation, in r	my opinion, de	ath occurr	ed at the time,	date and pl	ace, and due to	the cause(s)
	To T To I	Σ	29b. Signature and title of certifier	Niv.	0 14		29c. Lie	cense number	n		29d. Date s	signed (Month,	Daly, Year)
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1	11		30. Name and address of person	WIND COMPLETED ON	Togath (ite	m 23a) (Type,	/ // //	NAVII	1/111	the.	1971	to 1	1/2/2/18
	" Sta		31. Date filod (Month, Day, Year)		egistrar's Sign	ature &	Som	Mari V	000	11 }	0/1		4
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 24 2004 **Physician** November Beulah Murray /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1timbre SINAI If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 08 15 Year) 27 Birthplace (State or Foreign Country)
 SC 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 F 77 Yrs. Director 248-56-4338 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Funeral Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2817 Hilldale Ave 21215 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2X No Specify: Specify: Completed by 3 XWidowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th grade House Keeper Abacus Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be filt ment of Health and Mental H ant: If item 27 is marked oth Isaiah Carter Nora Stevenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 2817 Hilldale Ave, Baltimore, Md 21215 pate of Disposition (Name of 2000). Date 2000 Location - City or Town, State Ann Murray-Daughter 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 12/6/04 Owings Mills, Md 21. Signature of Funeral Service Liceasee 22. Name and Address of Facility March F/H West March F/H West 4300 Wabash Ave, Baltim shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death INFARCTION le nediate Cause (Final dease or condition resulting in death) MYOCARdi Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physiclan/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy signed by the atte Day Year Month 5 ☐ Other (specify) 4□Pregnant at time of death 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 Ho Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 🗋 Accident the 6 Could not be 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 THomicide o the Hospital within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatore and Nie of certifier 54558 SICIAN who completed cause of death (Item 23a) (Type, Print) IR MD 2401 W. Belvedere Ave Baltimore, mD21215 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DEC 01 2004

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and

of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 26, **Physician** ROSEMARY MacEVOY 2004 8:06A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Transitional Care Unit HMH Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Sex 1□M 2□F **Funeral** Months Days Hours Yrs. Director 152-05-6732 89 February 21, 1915 New Jersey Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits s 23a or 28a-f ehow 1 Yes XXNo Maryland Harford Forest Hill Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2719 Adv Road 21050 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ₩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status XXNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", al Hygiene. I other then "natura" event, I'te Maykgal E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Hospital 5+ith and Mental Hygid 27 is marked other r traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fiit Department of Health and Mental Hy Important: If Item Z7 is marked oth any injury or other traumatic event spice. James A MacEvov Josephine A Dignon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E Edwards JR POA 2719 Ady Road Forest Hill Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 remation 3 ☐ Removal from State GreenMount Cemetery 11/30/04 Baltimore, Maryland Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. gnature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complicy flons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause or each line. Immediate Cause (Final watton **Physician** Rumonia disease or condition resulting in death) 14 days /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Little of Jerying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cougestive 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an disease autopsy this certificate Cance 1 Yes 2 No 25. Was case referred to medical examiner?

1 
Yes 2 
Yes 26. Place of Death (Check only one) Hospital: Other: ursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After thi Manner of Math 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury M Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 1441060

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State Registrar 31. Date filed (Month, Day, Year)

STANLEM

32. Registrar's Signature

eted cause of death (Item 23a) (Type, Print)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | For State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** NOVEMBER FRANK ANGELO MESSINA 28, 2004 6:55 PMM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL CARROLL HOSPITAL CENTER WESTMINSTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign MARCH 24, 1950 PENNSYLVANIA 5. Social Security Number 9. Birthptace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Min. XM 2□F 194-40-2921 54 Yrs. Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show count be notified at 1 ☐ Yes 2√2 No Directo CARROLL WESTMINSTER MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 21157 15 KATE WAGNER COURT UNITED STATES or Items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Exeminer filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: VIETNAM 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) 12 WELDER/AUTO MECHANIC **MECHANICS** other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other treumatic event 90x8: 17. Father's Name (First, Middle, Last) Be BERNARD ANGELO MESSINA FRANCES L. GINNERY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WESTMINSTER, MD GAIL R. MESSINA/WIFE 15 KATE WAGNER COURT, 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Scremation 3 Removal from State 4 Donation 5 Other (Specify) CARROLL CREMATION 11/29/2004 HAMPSTEAD, MARYLAND 21. Signature of Funeral Service Licensea MYERS-DÜRBÖRAW FUNERAL HOME, P.A. 91 WILLIS STREET. WESTMINSTER, MD 21157 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) ASCUN **Physician** minutes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetat death 3 ☐ Ectopic pregnancy 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Yes 2 No 2 P/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Intury Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by

Box 68760 P.O. Division of Vital Records. Hospital or Attending Physician: Director: within 24 hours after c To the Funeral Direct completely filled in by

00051924 November 29. 2004 ,30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Henderson Manchester Rd Manchester MD 21107 Jr. MO 2973 Herbeit 32/Registrar's Signature 31. Date filed (Month, Day, Year)
DEC 0 1 2004 State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

25 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Dey, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certified

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. U Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:27 PM leluin 26 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 1 Year If Under 24 althmore 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (În yrs. last birthday) **Funeral** 1 M 2 □ F Yrs. Director Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23a or 28e-f show the Medical Exercines must be notified at 1 Yes 2 No Director andalistour 10e. Street and Number 10g. Citizen of What Country? Funerai . Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ BIACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. OO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) marked other then ntary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F pe Nea permit. Pages 1 and 2 should t Department of Health and Ment Importent: If item 27 Is marked 19b. Mailing Address (Street and Number or Rural Ruite Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method et bisposition 20c. Location - City or Town, State 1 W Burial 2 ☐ Cremation 3 Removal from State ŏ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility \augustander Funera 23a. Part1. Enter the 1se se, or complications that caused the death. Do not enter the mode of dying, such as call lac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): transit. The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a o. 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 4 Donknown 3 Probably been sign Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s has death2 certificate 2 No Division of Vital 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: or Attending 1 Natural 5 Pending within 24 hours after dean.

To the Funerel Director: Aft 2 □ No 1 🗌 Yes investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title 29c. License number M.D.

State Registrar

31. Date filed (Month, Day, DEC 0 1 2004 DHMH 17 Rev 1/2001

Name and address of person who

32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

M.D

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			Decedent's Name	e (First, Middle, La	ist)	8 12/0/	/U4 JH			2. Date of D	eath	3.	Time of Death
	Physici /Medio		Marian			Ni	cho1s			Month NOVEME		Year (2)(2)4 (2);	3:26AM
	Examir		4a. Facility Name (/				f	4b. City, Town, o	25.00		4c. County of		
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н	Funeral Director		478-01-77		Sex 1 □ M 2 <b>X</b> □ F		s. last birthday) 92 Yrs.	Months Days	If Under 24 Hours		lay, Year)	OTT.	(State or Foreign
	ט		Usual Residence of	Decedent			72			sept.	7, 1912	<del>OH</del>	TOMA
	anylan show d at	<u>.</u>	10a. State	10b. County		10c. (	City, Town or Lo	cation					side City Limits
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	leath ns 23	Funeral	11. Marital Status	Spring	Road 12. Was Deced	dent Ever in	IIS 13	Vas Decedent of h		? (Specify Yes or N	US.	A - American Inc	dian
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumatic event, Itte Medical Examinat must be notified at once.	by		ied 2 Married	Armed Ford 1 Yes 2 If Yes, Give Year or Da	ces? 2 🙀 No		f Yes, specify Cubin	an, Mexican, P	Puerto Rican, etc.)	Black	White, etc. White	uian,
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.O. Box	Physicien: The law requires that the death cert this certificate has been signed by the attending al director, page 2 should be detached for use	Completed by Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?		th 2 ☐ Fel ntat time of	tal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month	,	Year
۵.	s that	y P	Part II. Other signifi	cant conditions	ontributing to dea	ith but not re	sulting in the ur	derlying cause give	en in Part I.	23e. Did	tobacco use contrib	ute to the caus	se of death?
rds	quire an sig uld b	ed b	CHRONIC	OBSTRUCT	IVE PULM	ONARY	DISEAS	E		_ 1)2	Yes 2□No 3	Probably	4 Unknown
Division of Vital Records,	aw re	plet								24a. Was		re autopsy fini	dings available
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Ita	Physicien: this certifice ral director, p	Bec	25. Was case referrexaminer?	ed to medical					26. Place of	Death (Check only		105 2/4/10	-
<u>&gt;</u>	hysic this ce	2	1 ☐ Yes 2 💢				☐ ER/Outpatien	3□ DOA Othe	er: 4 ☐ Nursin	ig Home 5 ☐ Resi	dence 6 Other	(Specify)	
N C	ling P	lon:	27. Manner of Death	5 Pending		Injury Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe	how injury occurred		
<u>S</u>	ttendi death. ctor: A y the fu	icat	2 Accident 3 Suicide	investigation		f loiunz . At l	nome form etre	M 1 ☐ `	Yes 2 □ No	296 Leastine /	Connection	0 10	
<u>≥</u>	after after Dire	Certification;	4 Homicide	determined	building	, etc. (Spec	ify)	et, ractory, office		City or To	Street and Number wn, State)	or Hurai Houte	Number,
		Medical C	29a. Certifier (Check only one)	Certifying Ph	ysician: To the b niner: On the bas and manne	is of examin	owledge, death ation and/or inv	occurred at the timestigation, in my op	ne, date and pl	ace, and due to the courred at the time,	cause(s) and mann date and place, and	er as stated. I due to the ca	ause(s)
	Within To th	Me	29b. Signature and t	title of certifier	1			29c. License	e number		29d. Date signed (/	Month, Day, Ye	ear)
,			) (	)	Com	~ (	$\rightarrow$	n 2	7254		11/29/0	4	
6	110		30. Name and addre	ess of person who	completed cause	of death (Ite	m 23a) (Type, F		t Seed Seed "F				
1	1		31. Date filed (Month	J. J.M. M	D. 760	istrar's Sign	ER DR	IVE TOW	SON MA	ARYLAND	21204		
	Stat Registra	-			No.				,				
	, icgistic	2.7	UŁ	C 0 1 200	14 /2	alver.	de	Ann A	p.				

DHMH 17 Rev 1/2001

ORIGINAL

		1 - State of Maryl		artment of H		Reg.	ne N2004	37913
Physici /Medic		Decedent's Name (First, Middle, Last)     Barbara	Owings			2. Date of Death Month November	29 Year 2004	3. Time of Death  1:30 a M
Examin		4a. Facility Name (If not institution, give street and number) 6569 West Shady Side Road			Location of Death		4c. County of Death Anne Aruno	le1
Funeral Director		223-50-6618 ¹□ M <b>2XX</b> F	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Dec. 18,1	9. Birthpla Count Mary	ace (State or Foreig. ry) land
hours after death with the Maryland tural', or items 23c or 28a-1 show at Exar's art must be rediffed at	Funeral Director	Usual Residence of Decedent	. City, Town or Lo	Shady Sic	ie	100	. Citizen of What Count	od. Inside City Limits 1 ☐ Yes 2XXNo
23s or	al Di	6569 West Shady Side Road		207	764		USA	
be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or items 23s or 28a-f show event, the Medical Exam at must be recilified at	by	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever Armed Forces?  1 □ Yes 2 Mo If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 X No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Wh	
within 72 ha	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of worki	ng	b. Kind of Business/Ind	,
e filed w Il Hygier other th	e Cor	12 17. Father's Name (First, Middle, Last)	Secr	etary	18. Mother's Name	(First, Middle, Mai	floor Cover	ing
should be and Mental marked o	To Be	Edward Kidwell			Mary H.		,	
- 60 60 =		19a. Informant's Name/Relationship (Type, Print)  Robert D. Owings (Husband)					ity o <i>r Town, State, Zip (</i> ly <b>Side,</b> MD	
of Health of Health item 27 I		20a. Method of Disposition		osition (Name of matory or other place			c. Location - City or Tov	
Page tment c tant: If jury ou		'4 □Donation 5 □Other (Specify)	uaker C	emetery	12/2		Galesville,	MD
permit. Pages 1 Department of H Important: If ite eny injury or ot once.		21. Signature of Funeral/Gervice Licensee  23a. Part1. Enter the disease, or complications that caused the check, or heart failure. List only one cause on each line.			y Avenue	, Annapol	is, MD 2140	)1
/Medical Examiner  hysician and the purial-transit	Ical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a condition)  Due to (or as a condition)  Due to (or as a condition)	nse uence of					<i>J</i>
The law requires that the death certificate tte has been signed by the attending physoage 2 should be detached for use as the	Physiclan/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 mpnths? 1   Yes 2 UNo 9   Unknown	Fetal death 3[	□Ectopic pregnancy □ Other (specify)			23d. Date of deliver	y Day Year
puires that n signed b uld be deta	by	Part II. Other significant conditions contributing to death but not		inderlying cause give	en in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the	
	Completed	Debete Mellotic, The				24a. Was an autopsy performer 1 Yes 2	prior to com death?	sy findings availab pletion of cause of
Attending Physician: r death. ector: After this certific. by the funeral director,	tion; To Be	25. Was case referred to medical examiner?  1  Yes  No  Hospital: 1  Inpatient  27. Manner of eath	2 ER/Outpatie	f 28c. Injury Work	4   Nursing Hor	V	e 6  ☐Other (Specify)	
or or Dir	Certification	3   Suicide 4   Homicide 6   Could not be determined 28e. Place of Injury - building, etc. (St.		reet, factory, office	1	28f. Location (Stree City or Town, S	t and Number or Rural state)	Route Number,
the Hospitel hin 24 hours a the Funerel I npletely filled	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my Medical Examiner: On the basis of examiner and manner stated.	knowledge, deat πination and/or in	vestigation, in my op	pinion, death occurre	ed at the time, date	and place, and due to t	he cause(s)
To T Common	M	29b. Signature architile of certifier		29c. License	259	1	Date signed (Month, D	
10		30. Name and address of person who completed cause of death    Column   Col	(Item 23a) (Type,	Print- Stell	way SUIT	2100 A	NWAPORIS A	10,2140
Sta Regist		126 0 1 2004 Sener	a B	Sparks				

			1 - State Registrar	State of Maryland / Dep Ce	ertment of Health and Nertificate of Death	Mental Hygien	0
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physici /Medic		Diana Tangires	Poggi		November 2	28, 2004   12:31 P M
	Examin		4a. Facility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of Death		c. County of Death
			1201 A Boyce Ave.		Towson		Baltimore
п	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Year,	9. Birthplace (State or Foreign Country)
L	Director		220-07-7133 Usual Residence of Decedent	84 Yrs.		Jan 22, 1	920 Maryland
	/land		10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	Mar-184	tor	MD Baltimore	Tow	son		1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number		10f. Zip Code	10g. Ci	itizen of What Country?
	23a	ral	1201 Boyce Ave.	A	21 204-3604	U	nited States
	er de	Funeral		2. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
36	filed within 72 hours after death with the Maryland Hygiene ther than "natural", or items 23a or 28a-f show ant, If a Medical Exactivate east ke maithed at	by F	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 █ <b>\</b> No If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No Specify:		Specify: White
Ö	2 hou	Completed by	15. Decedent's Educa	ation 16a. Dece	edent's Usual Occupation	16b. K	Kind of Business/Industry
215	hin 7:	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)  (Give	e kind of work done during most of work DO NOT use retired)	ring	,
7	ad wit	Con	12		omemaker		Own Home
Ind	tal Hydrad	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Maider	n Sumame)
<u>₹</u>	should and Men s marke umatic	은	James H. Tangires	0.11		Maggis	
Maryland 21215-0036	d 2 sl th and th si traur		19a. Informant's Name/Relationship (Type Betsy McEvoy/daugh		ing Address <i>(Street and Number or Rui</i> 1 A Boyce Ave Tou	ai Houte Number, City ( JSON, MD.	or Town, State, Zip Code) 21204
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, If a Medical Experiment and the retified at Once.		20a. Method of Disposition	20b. Place of Disp	osition (Name of 12/0;	3/2004 <sup>20c. L.</sup>	ocation - City or Town, State
E	Pages nent of I int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  1 ☐ Donation 5 🗷 Other (Specify)	moval from State		•	monium, Maryland
alti	permit. Departm Importe eny inju	П	21. Sign, ure of Funcial Service Licensee	2	2. Name and Address of Facility Rt		Funeral Home, Inc.
<u> </u>	89 = 8 9	70			050 York Road, Tou		and 21204
		,	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the death. Do not en cause on each line.	iter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Pnysician	4 0	Immediate Cause (Final disease or condition resulting in death)	GLIOBLASTO	IN MULTI	FORME	Onset and Death  MONTHS
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	1 1.0-11		
	1	er	Sequentially list conditions, b.	Dualto (or es a consequence of):			
	outed id ansit	Examiner	day, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events				
Ó	e exectan ar		resulting in death) Last	Due to (or as a consequence of):			
8760,	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal	d.				
9 x	n certific anding p use as	an/Me	IF FEMALE:	c. If yes, outcome of pregnancy			
Вох	eath certifi attending   for use as	cian	in the past 12 months?	1 Live birth 2 Fetal death 3 €	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
0.	that the death led by the atter detached for u	Physicia	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9☐ Unknown			
	res that igned to be det	by P	Part II. Other significant conditions contr	ibuting to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco t	use contribute to the cause of death?
ğ	w require been sig should b					1 ☐ Yes 2	No 3 Probably 4 □Unknown
Records,	has be	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
		Con				performed? 1 ☐ Yes 2 Z No	death? 1 ☐ Yes 2 ☐ No
Vita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	spital:	Othor	(Check only one)	
o	Phys	. To	1 Yes 2X No 27. Manner of Death	28a. Date of Injury 28b. Time of	III 3 DOA 4 Nursing Ho	me 5 Residence 28d. Describe how injur	
on	Attending Pher death.	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		,
Division of	l or Attending after death. Director: After in by the funer	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street an City or Town, State	nd Number or Rural Route Number,
Ō	itel or irs aft rel Di	0					
	Hospite 24 hours Funerel stely filled	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my knowledge, deat or: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, ovestigation, in my opinion, death occurr	and due to the cause(s) ed at the time, date and	) and manner as stated. I place, and due to the cause(s)
	To the Hospitel or Attending Physicien: within 24 hours after deals. To the Funerel Director: After this certific completely filled in by the funeral director,	Med	29b. Signature and title of certifier	A	29c. License number	29d. Da	te signed (Month, Day, Year)
)	100		James Glo	111	134827	10	129/04
	00		30. Name and address of person who com	pleted cause of death (Item 23a) (Type,	Print)		1.7
	10		JAMES EBOLING 31. Date filed (Month, Day, Year)		ER DRIVE SVITE 101	TO WSON	MD 21204
	Sta Registr		DEC 0 1 2004	32. Registrar's Signature	1		

Amend item 20b per dvr 2838 12-16-04 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Year **Physician** 19, NOVEMBER CHARLES P. QUILL 2004 10:45AM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner PRINCE GEORGE 505 PRINCE GEORGE STREET LAUREL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) JULY 21,1942 6 Sax 7. Age (In yrs. lest birthday) Birthplace (State or Foreign
Country) **Funeral** Months Davs Hours 1√2 M 2□ F 220-40-3630 62 Yrs. MARYLAND Director Usuel Residence of Decedent filed within 72 hours after death with the Maryland Hygiena.

ther than "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiena. Important: If Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examines must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2 □ No Directo PRINCE GEORGE LAUREL 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 505 PRINCE GEORGE STREET 20707 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) DELIVERY MAN NEWSPAPER 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN THOMAS QUILL ELIZABETH PHELPS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) ELIZABETH QUILL / MOTHER 503 5TH STREET, LAUREL, MARYLAND 20707 20b. Place of Disposition (Name of ST cemet Managers CHP CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State 11-23-04 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST MARY'S CH. CEMETERY 11/23/04 LAUREL, MARYLAND 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MD 20707 Pert Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest. Approximate Interval Between Onset and Death **Physician** . Atheroscherotic Cardiovas ender Heart Disease Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner anding physician and use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) detached Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed by þ 8 24b. Were autopsy findings available prior to completion of cause of death? tha funeral director, page 2 should Completed 24a. Was an autopsy performed? peen has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To After this 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigetion 1 Natural after death. 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) Da 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) 3001 HOS SALVADOR 31. Date filed (Month, Day, Year) 32. Registrer's Signature State DEC 01 Registrar

State of Maryland / Department of Health and Mental Hygiezen 0 4 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOVEMBER 24, 2004 3:15 P. M WALTER AMOS RILEY JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1**X**] M 2□ F Months Days Hours Min. 398-14-6068 81 Yrs. Director 1923 WISCONSIN Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director GLEN BURNIE 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Items 23a UNITED STATES 21061 Funeral 529 WEST WAY 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No WWII IfYes, Give Year or Dates: KOREA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status should be filed within 72 hours after of the Mental Hygiene. marked other than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE þ Specify: 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER OPERATOR GOVERNMENT t of Health and Mental Hyging I filem 27 Is marked other or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 Is marked of 2 ALMA UNKNOWN WALTER AMOS RILEY, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 NORMAN AVE. GLEN BURNIE, MD 21060 CHERYL NORRIS/GUARDIAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition NOV. 26, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. ö 5 Other (Specify) 4 □ Donation METRO CREMATORY 2004 CATONSVILLE, MD 21. Signature of Funeral Service Licensee KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061
And caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
approximately a contract of the such as a cardiac or respiratory arrest, X. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 0115 /Medical Due to or as a consequence of): Examiner Neumana Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physiclan/Medical attending p IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Division of Vital 1 Yes 2 No 1 Tyes director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1-Natural 5 Pending Injury after death.

I Director: Af
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours af

To the Funerel D

completely filled in 29a, Certifier 🗜 configuing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10057635 Nov, 24, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Woons 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Year November 20 2004 1118 Lenore Doughten Rentfro /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Street Prince erry Brentwood If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Aug. 17, 1938 5. Social Security Number 6. Sex 7. Age (In vrs. last hirthday) Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 💢 F Yrs. Director 219-38-8854 Belgium. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expandrer must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Funeral Director Maryland Prince George's Brentwood 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3712 Perry Street 20722 U.S.A. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 2 Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Assistant Veteran's Affairs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Isaac Doughten III Adelma Merrill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pat W. Doughten - Brother 10928 Old Harrod's Woods, Louisville, KY 40223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11/26/04 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Gasch's Funeral Home, P.A. 37 4739 Baltimore Ave., Hyattsville, MD 20781 Part1. Enter the disease, or comshock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) , Wedical Counshot Wound to Head Examiner Examiner sician and bunal-transit requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buna Physician/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? signed by t 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 Yes 2 No 1 □ Yes 2 □ No • Hospital or Attending Physician: 24 hours efter death. • Funeral Director: After this certific: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 ∑Yes 2 □ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred SHUT 1 Natural 5 Pending investigation himselt in head 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3712 Pervy Dome , Brentwood unryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person who empleted cause of death (Item 23a) (Type, Print) 3001 Hospita 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

عتبر		State Registrar  1. Decedent's Name (First, Middle,	Last)		Cel	rtificate of	Dealli	2. Date of D		- U U H	3. Time of Deat
Physici /Medic		Colby	В.	Rucl	cer			Novemb	er 2	3 2004	12:40
Examin		4a. Facility Name (If not institution,		)		4b. City, Town, o	or Location of Death	1	4c.	. County of Dea	rth
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Funeral Director		217-38-1972 Usual Residence of Decedent	1 <b>XX</b> M 2□F	67	Yrs.	Months Days	Hours Min.	(Month, D	ay, Year)	937 Ma	thplace (State or For ountry) 1ryland
ueaur with the malyand ms 23a or 28a-f show Frust be notified at	tor	10a. State 10b. County  MD Anne A	rundel	10c. City, T	own or Lo	cation					10d. Inside City Lin 1 ☐ Yes 2 ☒
or 288	lrec	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Co	ountry?
23a	la	1430 Ridgeway E	ast				012			USA	
or Ita	by Funeral Director	<ul> <li>11. Marital Status</li> <li>1 ☐ Never Married</li></ul>	12. Was Decedent Armed Forces  1 XX Yes 2   1f Yes, Give Year or Dates:	? ] No		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race - Ame Black, Whit Specify:	
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and lamin		19a. Informant's Name/Relationshi				-	and Number or Ru				Zip Code)
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Department of Property of Important: If its eny injury or of once.		21. Signature of Funeral Service Li		Dias		Name and Addre	ess of Facility Funeral	Home P	.A.		50,00800
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ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	s a consequen	ice of):						
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ified within 72 hours after death with the Maryland Hygiene. Hygiene. Inter than "natural; or itams 23e or 28e-f show ant, it to Madical Examiner must be notified.	Funeral Director	11. Marital Status	12. Was Decede		l.S. 13.	Was Deced			gin? (Specif	y Yes or No- can, etc.)	14. Ra	ce - America	
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Funeral			Sex 7. Age (li 1. <b>X</b> [M 2□F	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birth	place (State or Fountry)
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Pal', o	þ	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates: WW	II	1 ☐ Yes 2 X No	Specify:		Specify: Wh	ite
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and is my		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Street	and Number or Rur	al Route Number, C	ity or Town, State, Zij	p Code)
itam 27 i		Craig Bradley R				ge Road,	Timonium,	MD 2109	3
f itar r oth		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐		Ob. Place of Dispo cemetery, crei	sition (Name of matory or other place	Nov.	Date 200	c. Location - City or T	own, State
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Russell,

		4	For State Registrer	State of Maryland / Depa	artment of Health and M <i>rtificate of Death</i>	ental Hygier	7111112 3	7922
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y	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Death	
				ITM	FANDALISTOWN		B. LITIMORE	
	Funeral		5. Social Security Number 6. Sec 215-28-9895	7. Age (In yrs. last birthday)  Yrs.	If Under 1 Year   If Under 24 Hrs.     Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace Country)	(State or Foreign
	Director	}	Usual Residence of Decedent	/1		7-3-17	22	MO
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:	or 28	Director	10e. Street and Number	1	10f. Zip Code	10g. (	Citizen of What Country?	
,	ath w		5506 E Heron		21215		45/4	
	er death with the Marylan Itams 23a or 28a-f show ret nivet be notified at	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - American Ir Black, White, etc.	ndian,
36	hours after death with the Maryland turet', or Itams 23a or 28a-f show al Ezami at must be nytilled al	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 <del>☐ N</del> o If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Blace	· K
21215-0036	"natural", idical Exe		15. Decedent's Edu	cation 16a. Dece	dent's Usual Occupation	16b.	Kind of Business/Industr	у
215	within 72 ene. than "na he Medic	pie	(Specify only highest grad	e completed) (Give life.	kind of work done during most of working NOT use retired)	_	<u> </u>	0 1
	filed with Hygiene. other than ent, the M	Completed			eacher		Baltimore	City
nu	d d d	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maid	en Sumame)	
Z s	should be ind Mental s marked o umatic eve	은	John K. II	lurphy	Cece 1	a Pu	rnell	
= 4	7 ra 12	1	19a. Informant's Name/Relationship (Ty	10 . 0	ng Address (Street and Number or Rura		MD 21241	
	teal teal am 2	1 1	20a. Method of Disposition	20b. Place of Dispo	osition (Name of		Location - City or Town,	
OH.	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	matory or other place)	-04 B	-16 m(1)	
	그 등 환경	i	21. Signature of Funeral Service Licens	11410 1C	2. N and Address of Facility US 4	ahn C Green	re Funeral Se	AUCER
ä	Deparenti Importanti any ir		12 horale CC	ele 8	728Liberta Rd Ra	nde Ilston	s com no	1133
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications tha caused the death. Do not ent			App	roximate rval Between
F	Physician /Medical Examiner		Immediate Cause (Final disease or condition	Sepsis				set and Death
			resulting in death)	Due to (or as a consequence of):			'	0.000
	LAdillillei	_	Sequentially list conditions,	Due to (or as a consequence of):	my failure			1 day
	ted nslt	nine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequence or).	•			
<u>,</u>	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a consequence of):				
8760	cate be executed obysician and the burial-transit	dicail		d				
		Medi	In Frankin					
Вох	eath certifi attending I I for use as	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of delivery Month Day	
0.	requires that the death certifi seen signed by the attending I hould be detached for use as	Physician/Me	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at time of death 5□ 9□Unknown	Other (specify)		Month Day	Year
P.	that the de ed by the a detached			ntributing to death but not resulting in the u	nderlying cause given in Part I	23e Did tobacco	o use contribute to the ca	use of death?
Vital Records,	signe d be	d by	•				2 No 3 Probably	4 Unknown
COL	w requir been si should	lete				24a. Was an	24b. Were autopsy f	indings available
Re	ihe law ate has b page 2 st	Completed				autopsy performed?	prior to complet death?	tion of cause of
tal		0	25. Was case referred to medical		26. Place of Death	(Check only one)	vo 1 ☐ Yes 2 🔀	No
>	nysrcian: ils certifica director,	00	examiner? 1 \( \sum \) Yes 2 \( \sum \) No	lospital: Inpatient 2 ER/Outpatier	Othor		6 □Other (Specify)	
	lysic direc	0			The state of the s		iury occurred	
0	<u> </u>	P	27. Manner of Death	28a. Date of Injury 28b. Time of (Month, Day Year) Injury	f 28c. Injury at 2 Work?	8d. Describe how in	,,	
S	Ing Pt	P	27. Manner of Death  1 Natural 5 Pending investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
-	or Attending Priter death. irector: After the by the funeral	P	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)  28b. Time of Injury  28e. Place of Injury - At home, farm, str building, etc. (Specify)	Work? M 1 ☐ Yes 2 ☐ No		and Number or Rural Rot	ite Number,
-	or Attending Priter death. irector: After the by the funeral	Certification; To	27. Manner of Death  1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) Injury  28e. Place of Injury - At home, farm, str building, etc. (Specify)	Work?  M 1 ☐ Yes 2 ☐ No  eet, factory, office	8f. Location (Street a City or Town, Sta	and Number or Rural Rot tte)	
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-	or Attending Priter death. irector: After the by the funeral	P	27. Manger of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only) 2 Medicel Exemi	(Month, Day Year) Injury  28e. Place of Injury - At home, farm, str building, etc. (Specify)  sicien: To the best of my knowledge, deather: On the basis of examination and/or in	Work?  1 ☐ Yes 2 ☐ No  reet, factory, office  2  h occurred at the time, date and place, a	.8f. Location (Street in City or Town, Standard due to the cause) at the time, date a	and Number or Aural Rotate)  (s) and manner as stated	cause(s)
-	Attending Pt st death. ector: After th by the funeral	edical Certification; To	27. Manger of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  27 Medicel Exemi	(Month, Day Year) Injury  28e. Place of Injury - At home, farm, str building, etc. (Specify)  sicien: To the best of my knowledge, deather: On the basis of examination and/or in	Work?  1 Yes 2 No  eet, factory, office  a cocurred at the time, date and place, a vestigation, in my opinion, death occurred  29c. License number	.88f. Location (Street in City or Town, Sta	and Number or Rural Rotate)  (s) and manner as stated and place, and due to the place signed (Month, Day,	cause(s)  Year)
-	or Attending Priter death. irector: After the by the funeral	edical Certification; To	27. Manger of Death  1 Natural 2 Accident 3 Suicede 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	(Month, Day Year) Injury  28e. Place of Injury - At home, farm, str building, etc. (Specify)  sicien: To the best of my knowledge, deather: On the basis of examination and/or in and manner stated.	Work?  1 □ Yes 2 □ No  reet, factory, office  2 to a control of the control of t	.88f. Location (Street in City or Town, Sta	and Number or Rural Rotate)  (s) and manner as stated and place, and due to the place signed (Month, Day,	cause(s)  Year)
-	or Attending Priter death. irector: After the by the funeral	Medical Certification; To	27. Manger of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who compared to the compared to the certifier  30. Name and address of person who compared to the certifier	(Month, Day Year) Injury  28e. Place of Injury - At home, farm, str building, etc. (Specify)  sicien: To the best of my knowledge, deather: On the basis of examination and/or in and manner stated.	Work?  1 □ Yes 2 □ No  eet, factory, office  a vestigation, in my opinion, death occurred  29c. License number  □ 005 9736  Print)	nd due to the cause dat the time, date a	and Number or Rural Rotate)  (s) and manner as stated and place, and due to the place signed (Month, Day,	cause(s)

riex	I COLI		1 - For Stata Registrar		State of	Maryland /		ment of H		d Menta	l Hygiei	7 11 11 14	3	7923
			1. Decedent's Name	First, Middle, Las	st)						e of Death			Time of Death
	Physici		AHMED ROBINSON					Month Day Year November 28, 2004 17						7:48 M
	/Medic Examir		4a. Facility Name (I			7.34	4	4b. City, Town, or Location of Death  4c. County of Death						
1			3015 Han	lon Avenu	ie			В	altimo	ce		N	IA	
	Funeral Director		5. Social Security N 218-60		ex	Age (In yrs. last t		f Under 1 Year fonths Days	If Under 24 I	Ain. 8. Dat	e of Birth nth, Day, Ye	ar) 1955	Birthplace Country)	(State or Foreign
	pu 🎽		Usual Residence of 10a. State	Decedent 10b. County		10c. City, To	un or Locat	ion					104 4	nside City Limits
	aryta shor	_	MD	N/	4	Toc. City, 10	A 11		SOF	07	TV			Pres 2 □ No
	Ba-f	ectc		141			DAT	ISING	RE	4	7			2.00 2
	with t	ā	10e. Street and Nur	noer		1.1-	_	10f. Zip Code	2/1/	•	109.	Citizen of What	Country?	
	s 23	erai	3013	MANIC	12. Was Decede	HUENUE	13 14/2	c Decedent of H	4046	2 (Spoothy Va	o os No	14. Race - A	morican In	dian
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-1 show other traumatic event. The Medical Examinat must be rotified at	by Funeral Director	<ul><li>11. Marital Status</li><li>1 ☐ Never Marri</li><li>3 ☐ Widowed</li></ul>	ed 2 Married 4 Divorced	Armed Force 1 Tes 2 If Yes, Give Year or Date	es? No		s Decedent of Hes, specify Cuba	Specify:	uerto Rican,	etc.)	Black, W		CK
Ō	2 ho	Completed	/Sans	15. Decedent's Ed	ducation	16	a. Deceden	t's Usual Occup	ation	working	16b	. Kind of Busine	ss/Industr	,
21	e. e. "r	ple	Elementary/Seco		College (1-4	or 5+)		d of work done o NOT use retired			0	WESTZ	NG.	HOUSE
2	filed wil Hygien other th	Con	1274		1 YEA	AR	ELE	ECTA	CIA	1/		CORPO	RAT	TON
pu	should be filed withir nd Mental Hygiene. marked other than imatic event, the Ma	Be (	17. Father's Name	(First, Middle, Last)	1	111			18. Mother's	Name (First,	Middle, Maid	ien Sumame)		
<u> a</u>	should but and Ment	일	CALV	TN C	. KO.	BINSC	W		JA	NE	E.	MA	501	<b>(</b>
Maryland	2 sho and is m		19a. Informant's Na	me/Relationship (	Туре, Print) (S	757ER 19	b. Mailing A	Address (Street	and Number o	r Rural Route	Number, Cit	y or Town, State	, Zip Cod	2/2/8
100	and sealth m 27		SORAY	4 A. K	ROBINSO	W -	1921	(ED)	YOR	RD,	BAL	TIMOR	E	MD
Baltimore	permit. Pages 1 a Department of Hes Important: If item any injury or othe		20a. Method of Disp	oosition Cremation 3 [	Removal from St	comot	of Disposition of Dis	on (Name of ory or other plac	θ)	Date	20c.	Location - City	or Town, S	State
Ĕ				5 Other (Specify		META	0 0	REMA	TORY.	143/	04 6	27ans	1411	E, MD
alt			21. Signature	neral Service Licen	1500	V	22. N	ame and Addres	s of Facility	HOWE	UF	UNER	He.	Home
Ω	8 9 E 8			When.	11. 0	nous	46	00 LI	352TY	HSH	73 M	BAL	10, M	0 21207
	Physician		23a. Primer ther the sock of heat limmer the Cause diseas or condition	he disease, or com ntf ure. List only (Final n	one cause on eac	sed the dead. Do						Diagram	App Inte Ons	roximate rval Between et and Death
	/Medical		resulting in death)		Due to (or	as a consequence	e of):	ECTISTOF	ic care	LLOVas	urat	Disease		
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	p =	Examiner	if any, leading to in	nmediate	Due to (or	as a consequence	e of):						ļļ.	
	icate be executed physician and the burial-transit	ami	Cause (Disease or that initiated events	•	c									
0,	cate be execui physician and the burial-tra	Ë	resulting in death) I	Last	Due to (or	as a consequence	e of):							
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9	‡ o α		IF FEMALE:					-					-	
.O. Box	uires that the death certifi signed by the attending I d be detached for use as	by Physician/M	23b. Was deceden in the past 12 1 Tes 2 5	months? ☐ No		h 2 Fetal dea nt at time of death		topic pregnancy				23d. Date of Month	delivery Day	Year
Δ.	law requires that the as been signed by th 2 should be detache	'Ph	Part II. Other signif	icant conditions c	ontributing to dea	th but not resulting	in the unde	orlying cause give	en in Part I.	23	e. Did tobaco	o use contribute	to the car	use of death?
ds,	sign d be										1 🗆 Yes	2 No 3	Probably	4 Unknown
Ö	w require been sig should t	ete								_		7		
Records,		Completed								_ 24	a. Was an autopsy	prior	o complet	ndings available ion of cause of
4	cate h	Ö								1	performed Yes 2X	No 1 Y		No
Vital	ilcian: Th certificate rector, pag	Be	25. Was case refer examiner?		Hospital:			Oth	26. Place of					
of	Physician: r this certific ral director,	은	1 X Yes 2 ☐ 27. Manner of Deat		. 1 🗀 tub		Outpatient Time of	3 DOA Oth	4 🗀 (40) 311			6XXX ther (S	pecify) S	CENE
u C	ing l	lo	1 Natural	5 Pending	28a. Date of (Month,	Day Year)	Injury	28c. Injun Worl		28G. De	scribe now in	ijury occurred		
Division	Attending in death. ector: After by the fune	Certification:	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be					Yes 2□No	204 1			0 10	
Ξ	fter of Jirec in by	THE LE	4 Homicide	determined	28e. Place of	Injury - At home, , etc. (Specify)	iarm, street	, factory, office		City	or Town, St	and Number or ate)	нигал нов	re rvum ber,
L	pital urs a sral E	ပို	20- 0	4000000	1		4			1		4->		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely illed in by the funeral director.	edical	29a. Certifier (Check only one)	1☐ Certifying Ph 2X Medicel Exam	ninar: On the bas	is of examination a	ge, death oo und/or inves	curred at the tin tigation, in my o	ne, date and pl pinion, death o	ace, and due occurred at th	to the cause e time, date a	e(s) and manner and place, and c	as stated. lue to the	cause(s)
	ithin ;	Med	28b. Signature and	title of certifier A	and manne	i Sidleu.		29c. Licens	number		29d	Date signed (Mo	nth, Dav	Year)
	£ ₹ 8	1	Ma	- 1	an Ul	10 /	us	2.50.10	O.C.M.	E.		vember 2		
	1/		MUL	pue 1	ine mu				0.0.11.		140	v estable 4	, 2	
Y	JV		30. Name and addr			of death (Item 23a REUL	111 P	enn Str	eet, Ba	altimo	ne, Mar	ryland 2	21201	
	-01		31. Date filed (Mon	th, Day, Year)		gistrar's Signature					-	-		
	Sta Regist	ate rar		DEC 0 1 2		egera	6	Louis	2					

		For State Registrar	State of	Marylar		artment of H		nd Mental Hy	giene Reg. No 2	004	370	221.	
Dhuaisi		1. Decedent's Name (First, Middle	e, Last)					2. Date of De	aath Day	Year	Death		
Physici /Medio		Emelda Sophia R	osette			<u> </u>		Novemb		2004	3:00	м ф	
Examin		4a. Facility Name (If not institution	-	nber)		4b. City, Town, or	Location of	Death	4c. Cour	nty of Death			
		Joseph Richey H					altimo		N/A	<del></del>			
Funeral Director		5. Social Security Number 437-90-6639	6. Sex 1 □ M 2 <b>X</b> F	7. Age (in yrs.	54 Yrs.	If Under 1 Year Months Days	Hours 24	Min. 8. Date of Bi (Month, Date of Aug 5,	ay, Year)	Cou	place (State o ntry) Siana	or Foreign	
and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					0d. Inside C	ity Limits	
Maryl	ō	MD Harfor	rd	Fda	rewood						1 🗌 Yes		
28a	Director	10e. Street and Number	- C	Lag	cwood	10f. Zip Code			10g. Citizen o	of What Cour	ntry?		
3a o		827 St. George	Court			21040			United	State	es		
death	Funeral	11. Marital Status	12. Was Dece		I.S. 13.	Was Decedent of Hi	spanic Origi	n? (Specify Yes or No		ace - Ameri			
be filed within 72 hours after death with the Maryland Ital Hyglene. In the Hyglene. In the Maryland, or Items 23a or 28a-f show event, the Mariland Exerting from the natified of	by	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	ied Armed For 1 Tes If Yes, Giv Year or Da	2 <b>X</b> No		If Yes, specify Cuba 1 ☐ Yes 2 🗷 No	n, мөхісап, Specify:	Pueno Rican, etc.)		tack, White, cify: Black			
"natural"	ted		t's Education		16a. Dece	dent's Usual Occupa	ation		16b. Kind of				
hin 7 9.	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1	-4or 5+)	lite.	kind of work done of DO NOT use retired	luring most o )	of working	Own Ho	me			
od wit	Son	10			Homem	aker							
be filed within 72 h tal Hygiene. d other than "natu event, the Medical	Be (	17. Father's Name (First, Middle,	Last)					s Name (First, Middle		ame)			
Ment Ment arke	၉	Isiah Gross					Martha						
2 shot and Is m		19a. Informant's Name/Relations			1	-		or Rural Route Numb			Code)		
and tealth m 27 her t		Doreen Rosett/D	aughter	205 [		t. George sition (Name of	Court	t, Edgewoo					
ges 1 If of F If ite or ot		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation		. ! (	cemetery, cre.	matory or other plac S Unite	9)	Date Dec 4	20c. Location				
t. Pa rtmen rtant:	. 19	'4 □Donation 5 □ Other (S		Me	thodi	st Cem.	4	2004	Hahnvi	ile, I	A		
permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiens Important: If item 27 is marked other than "in any injury or other traumatic event, the Medicans.		21. Signature of Funeral Service	nuiann	_ M003	82	remation 3717 Greer	and F	2004 uneral Alt ures Drive	ernati Balt	ves imore,	MD		
Physician /Medical		23a. Part1. Erfer the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_ a. ////	aused the deaf ach line or as a consec	le,	ter the mode of dying	y, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Bette Onset and I	ween	
The law requires that the death certificate be executed at the death certificate be executed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last	с	or as a consec		/				/			
at the death certific by the attending parached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outd 1 ☐ Live bi 4 ☐ Pregna 9 ☐ Unkno	aldeath 3[	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day Year					
ires that signed by	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in							23e. Did tobacco use contribute to the cause of deat				
w require been si should b	etec									/			
: The lav	Completed							24a. Was auto perfo		prior to condeath?	psy findings a mpletion of ca 2□ No	available ause of	
sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital			Otho		f Death (Check only o	one)	/	16	- 1 1 1	
Phys this al di	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin 2 Accident Investig	28a. Date o	·	28b. Time o Injury	f 28c. Injury Work	4 14013	28d. Describe		ther (Specifi urred	H059	71CE	
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident INVESTIG	not be 28e. Place	of Injury - At h	ome, farm, str	reet, factory, office		28f. Location ( City or To	Street and Nur wn, State)	nber or Rura	l Route Num	ber,	
e Hospit 124 hours e Funera letely fille	edical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physicien: To the Examiner: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurred at the tim vestigation, in my op	e, date and pinion, death	place, and due to the occurred at the time,	cause(s) and r date and place	manner as si e, and due to	ated. the cause(s	)	
To th withir To th comp	Me	29. Signature and title of certifie	Pine	40	M	29c. License	number	2	29d. Date/sign	ned (Mo th,	Day, Year)		
21		30. Non earnd address of person	who complet cause	e of death (Iter	n 23a) (Type,	Pyint)	IR	1 124/1	11/26	109	Ma.	411	
Sta	tę	31. Date filed (Month, Day, Year)	JYM2/32.1916	43// egistrar's Signa	MAG ature	eryoda	NH	POST	11110/1	19/19	11/1/	2/8	
Registr		DEC 0 1 2	2004	person	15	pources	,						

11-28-04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NOWEMBER 28, 2004 9:30 PM ROBERT CLAYTON ROY, SR. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death
CARROLL 4b. City, Town, or Location of Death Examiner FINKSBURG 1612 WALTER AVENUE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1**√**M 2□ F Months Days Hours Year) Yrs. Director 221-14-4541 80 1924 28, NEW JERSEY Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 📉 🖔 Director MARYLAND CARROLL FINKSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1612 WALTER AVENUE 21048 UNITED STATES or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XXes 2 ☐ No 1 ☐ Yes 2 📉 To Š Specify: XXWidowed 4 Divorced Year or Dates: WWII "natural", WHITE Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER ENGINEER COMPUTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hisant: If item 27 is marked oth OSCAR PETERSEN ROY ALICE MAE SHINN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a cortant: If item 27 is injury or other trav LINDA L. ROY/DAUGHTER 24 JACK PINE PLACE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/2/2004 permit. Page Department o Important: If any injury or once. EVERGREEN MEMORIAL GARDENS FINKSBURG, MARYLAND 21. Si ature of Funeral Service Licenses 22. Name and Address of Facility
MYERS—DURBORAW FUNERAL HOME, P.A. 91 WILLIS STREET, WESTMINSTER, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART /Medical Due to (or as a consequence of) Examiner Due (or as a consequence of): Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit NISE-SE Due to (or as a consequence of) physician s the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗀 Suicide

The law requires that the death certificate be executed Box 68760. Records, P.O. Division of Vital or Attending Physician: in by the tuneral Certification: death after death

within 24 hours a

death with

filed within 72 hours after

Baltimore, Maryland 21215-0036

Medical To the

29a. Certifier 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DO1663

30. Name and address of person who completed cause of death (Item 23a) (Type/Print) VINCENT J. FIOCCO M.D.

447 EAST MAIN STREET,

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

WESTMINSTER, MD

31. Date filed (Month, Day, Year) State Registrar

4 Homicide

determined

32. Registrar's Signature

	r Ahmad -07458 D	. S	arshar Plea Amend Item 20 1- For Amend Item Registrar	ase Type or l b per FH. State o n 20b-c per	Print in I 2838, 12 Maryiar r fh G8	3lack Ind /01/04/ 10/10/20 38 12- <i>Cei</i>	delible dhb innen 10-04 tificati	t of H	<b>Ensu</b> lealth a	ire Al and M	I Copies Iental Hy	s Are	e <b>Legi</b> lle le	ble.	37026		
	Physici	an	1. Decedent's Name (First, Midd	fle, Last)		14					2. Date of De	eath		Year.	3. Time of Death		
	/Medi	al	Mir Ahmad Sars		nhar)		4h Cih	Tour or	. Loontine	of Dooth	Novemb			2004	0730 Рм		
	Examir	Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Dulaney Valley Road & Seminary Avenue Lutherville  Balti															
	Funeral Director		5. Social Security Number 212-44-1359	6. Sex 1 🔀 M 2 🗆 F	7. Age (In yrs. 73	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di Jan. 2]	rth ay, Year	932	9. Birthpla Counti	ice (State or Foreign y) Iran		
	death with the Maryland ms 23e or 28a-f show	1	Usual Residence of Decedent  10a. State 10b. Count			y, Town or Lo								10	d. Inside City Limits		
	the Maryla 28a-f shoy	Director	MD Balti  10e. Street and Number	more	Luti	nervill	e 10f. Zip	Code				10a C	itizen of M	Vhat Count	1 ☐ Yes 2 🛣 No		
	23e or		1500 Sherbrook	Road			2109					USA		mat Count	<i>y</i> .		
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336	hours after turel', or ite	by F	1 ☐ Never Married 2 📉 Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes Giv	0	1	I□Yes :	2 💢 No	Specify:				Specify	whi.	te		
2-0	72	eted	15. Decede (Specify only high	nt's Education est grade completed)		16a. Deced	lent's Usua kind of wor	il Occupa	ation during mos	t of worki	na	16b. I	Kind of Bu	siness/Indu			
21215-0036	withir ane. than	completed	Elementary/Secondary (0-12)	College (1	-4or 5+) +	Surgeo	DO NOT us	e retired	i)		9	Med	licine	9			
pu	ild be filed lental Hygie rked other ic event, the	BeC	17. Father's Name (First, Middle						18. Mothe	r's Name	(First, Middle	, Maide	n Surnam	θ)			
Maryland	2 should be and Mental Is marked reumetic ev	ည	Sayyed Taghi Sai	<u>_</u>	•	19h. Mailin	o Address	(Street a	Robal		Asht Asht		or Town	State Zin (	ode)		
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altimore,	ges 1 au t of Hea If item or othe		20a. Method of Disposition 1 🗷 Burial 2 □ Cremation	3 □Removal from 5	20b. F	Place of Disposemetery, crept aney Va	sition (Nan	ne of ther olae	ink orial		ate Unk			City or Tow			
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Ba	permit. Departi Importi eny inj		1 /eth	Qua							Home			York F	oad 21204		
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68760,	aath certificate be executed attending physician and for use as the burial-transit	Physician/Medical Examiner	_	_	cause. Enter Underfung Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseq										
P.O. Box 6	0 0 D				ysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		rth 2 ☐ Feta ant at time of d	Ideath 3□	Ectopic pro Other (sp						23d. Date Mon	of delivery th D
	sign sign	by	Part II. Other significant conditi	ions contributing to de	ath but not res	ulting in the un	iderlying ca	ause give	en in Part I.		23e. Did t		7		cause of death?		
Vital Records,	The law ate has b page 2 st	Completed									100 Yes	psy ormed? 2 \Begin{align*} No	pr d	nor to comp atb?	y findings available letion of cause of		
. Vit	Physicien: this certific ral director,	o Be	25. Was case referred to medica examiner?  1 ☒ Yes = 2 ☐ No	Hospital:	patient 2	ER/Outpatient	3 DO	A Othe			( <i>Check only c</i> ne 5 ☐ Resi		6 <b>XX</b> Othe	r (Specific)	At Scene		
ion of	Attending Physrdeath. cdeath. ector: Atter this	ation: T	27. Manner of Death  1 Natural 5 Pendi 2 ccident invest	ng 28a. Date of (Monti		28b. Time of laury		Bc. Injury Work		, 2	28d. Describe				Cydat		
Division	P affe	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 228. Finds	of Injury - At ho g, etc. <i>(Specif</i> )	ome, farm, stre	et, factory	, office		0	28f. Location ( City or To	Street ar	nd Numbe	r or Ruyal F	Route Number,		
	Hospitel 24 hours 6 Funeral (tely filled	Medical	29a. Certifier 1 Certifyi (Check only 2X Medical	ng Physician: To the Examiner: On the ba	sis of examina	wledge, death tion and/or inv	occurred a	at the tim in my op	e, date an	d place, a	and due to the	cause(s date an	s) and man	ner as state	ed. ne cause(s)		
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	6	/	X O Lu	2 teans			C	.C.N	1.E.			Nove	ember	20,	2004		
	N. W.		30. Name and address of person	ho yet	M	111 P		stree	et, B	altir	nore, M	lary.	land	21201			
	Sta Registr		31. Date filed (Month, Day, Year, DEC 01 2004		igistrar's Signa		ach	/									

Amend item#19a, per INI, G838, 1276/04 Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Continues of Death 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Skovira 29, John Α. November 2004 2:05 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium Baltimore Under 1 Year If Under 24 Hrs. onths Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 XM 2□ F Months Director 132-09-0170 90 26, 1914 Pennsylvania Usual Residence of Decedent the Maryland 10a, State 10c. City. Town or Location 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evans har must be notified at 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2525 Pot Spring Road Apt. L527 21093 Funerai U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after ☐Yes 2 f Yes, Give 1 ☐ Never Married 2 X Married 2 X No 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Technical Writer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Skovira John Mary Gavenda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau Shovira 2525 Pot Spring Road Apt. L527 Wife Kathryn Timonium, Maryland 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4 Donation 3 Other (Specify)
21. Single- Funeral Sproise Licensee Hillton Service Corp. 12-2-2004 Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part I. Enter the disease, or opmplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician BRAIN TUMOR /Medical Due to (or as a consequence of): Examiner. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine sician and burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? 2 No 1 Yes uneral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 ☐ Yes 2 🙀 No 4 ☐ Nursing Home 5 ☐ Residence 6 ★ ther (Specify) HOSPICE 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of al or Attending P s after death. Il Director; After t 28d. Describe how injury occurred Certification: 1 X Natural 2 ☐ Accident 5 Pending investigation 1 Tes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \ Homicide To the Hospital within 24 hours at To the Funeral D Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 29c. License number

Registrar DHMH 17 Rev 1/2001

State

NOVEMBER 29, 2004

Box 68760

P.O.

Division of Vital Records,

JOHN SKOVIRA

**ORIGINAL** 

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

32, Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

DEC 0 1 2004

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vaar **Physician** Month Lillian May Smith November 29, /Medical 2004 9:30 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8004 Oakleigh Road Parkville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2**X**F Months 86 Yrs. Director 212-07-9509 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Parkville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? õ Itams 23a 8004 Oakleigh Road 21234 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Specify: White Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ₩Widowed 4 Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Grocery is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Meat Packer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be f and Mental H James Meek Marie Kaufman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any Injury or other traum once. Mr. Leo Smith/Son 1723 Pin Oak Road, Parkville, MD 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nov 30 1 ☐ Burial 2 Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD 2004 21. Signature of Funeral 22. Name and Address of Facility Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prysitian Ung months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Useass or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760 physician Physician/Medical the Ses attending IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 Other (specify) the Records, P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed Division of Vital 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death Check onl. one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/30/04 D0028949 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8113 Harford RA Swite 100 Baltimore MD 21234 -7ATZ15 PANAYIOTIS 31. Date filed (Month, Day, Year) 32. Régistrar's Signature DEC 0 1 2004 Registrar

			1 - For State Registrar	State of Maryland	d / Depa			•	2001.	37929
	Physic	ian	1. Decedent's Name (First, Middle, Last	")				2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Cora Dorot  4a. Facility Name (If not institution, give	thy Schriver		4h City Tow	n, or Location of Death	Nov. 28.	2004 4c. County of Deat	4:35 A M
	Examir	ier	Gilchrist				owson		Balti	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la		If Under 1 Ye Months Da	ar If Under 24 Hrs. ys Hours Min.	8. Date of Birth (Month, Day, Ye NOV. 18,	9. Birt	tholace (State or Foreign
	Director		Usual Residence of Decedent	M 2MF 89	Yrs.		,	Nov. 18,	1915	Maryland
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	72 hours after death with the Maryland naturel', or Items 23a or 28e-1 show areal Examiner must be marified at	Funeral Director	62 Theo Lane	12. Was Decedent Ever in U.S	13 1		21204	cifu Vac or No	USA 14. Race - Ame	vices Indias
ယ္	after d or Item officer		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No			of Hispanic Origin? (Spe cuban, Mexican, Puerto F	Rican, etc.)	Black, Whit	
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21215-0036	"natu	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Deced	lent's Usual Oc kind of work do	cupation ne during most of workir tired)	16b	. Kind of Business/	Industry
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	be filed tal Hygid d other	Be C	17. Father's Name (First, Middle, Last)			,,,,,,,,,	18. Mother's Name	(First, Middle, Mai		
ylaı	should b nd Ments marked	ToE	Wiley Macher	ı, Sr.			Carr	ie Hewit	t	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "naturel", or Items 23a or 28e-f show any njury or other traumatic event, the Macical Examiner must be notified at once.		19a. Informant's Name/Relationship (7)				eet and Number or Rura			Zip Code)
	1 and Healti em 2		Mr. Harry C. Schriv 20a. Method of Disposition	20b, Pla	ce of Dispos	eo Lane sition <i>(Name of</i>	D		21204 Location - City or	Town State
Baltimore,	ages ent of nt: If it		1 XBurial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	metery, cren	natory or other ; emetery	olace)			
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8760,	Physician and with price of parameter price of para	icai Examiner	23a. Part1. Enter the disease, or confishors, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	4100	ance of):		sm Ling			Interval Between Onset and Death Mu 4 The
O. Box 6	or Attending Physician: The law requires that the death certificate be executed titler death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1	leath 3 🗌	Ectopic pregna Other (specify)			23d. Date of deli Month	very Day Year
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al Records,	sician: The law certificate has b	e Completed						24a. Was an autopsy performed 1 Yes 25	prior to death?	topsy findings available completion of cause of
Vital	/sicia s certi directo	0 8	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ El	R/Outpatient	3 □ DOA	26. Place of Death	(Check only one) le 5 ☐ Residence	Markey (Com	
sion of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. In		8d. Describe how in	-	Hospice
Division	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)				City or Town, St		
	To the Hospital within 24 hours a To the Funerel I completely filled	Medicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowl ner: On the basis of examinatio and manner stated.	ledge, death on and/or inv	occurred at the estigation, in m	time, date and place, as y opinion, death occurre	nd due to the cause d at the time, date :	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within Fo the Somple	Me	29b. Signature and title of certifier	2 /		29c. Lice	nse number	29d.	Date signed (Month	, Day, Year)
	1		) Joseph	Sail 6	40	00	061199		Nov 28	2004
1	) (K)		30. Name and address of person who co	K	66	Print)	Charles Str		ltimore,	
:	Sta Registr	- 1	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re by	Sport	la)			

Ö			1 - For State Registrar	State of Maryland	/ Depa <i>Cer</i>	rtment of H tificate of I	lealth and M Death		ene 004	37930	
			Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death	
	Physici /Medic	Marvaret M. Soares								M	
	Examin		4a. Facility Name (If not institution, give stre Rt. 32 @ Linden Chu				Location of Death		4c. County of Di Howard		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. E	Birthplace (State or Foreign Country)	
	Director		Usual Residence of Decedent	<sup>2</sup> ₹ 49	Yrs.			9-10-19		ryland	
	yland now		10a. State 10b. County	10c. City, T	own or Loc	cation				10d. Inside City Limits	
	a-fsh	ctor	MD Anne Arund	le1 Laur	e1					1 ☐ Yes 2 ☐ No	
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?	
	9ath v	Funeral	342 Eagle Harbor S.	Was Decedent Ever in U.S.	12 W	20724	ispanic Origin? (Spe	aifu Vac or No	USA	merican Indian,	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other treumetic event, the Modical Examited in 1810s multiped at once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	11	Yes, specify Cuba	Specify:	Rican, etc.)	Black, W		
21215-0036	nin 72 hoi s. in "neturi Modical I	Completed	15. Decedent's Educati (Specify only highest grade or		6a. Deced (Give I life. D	ent's Usual Occupa kind of work done of NOT use retired	ation during most of workii )	ng 1	6b. Kind of Busine	ss/Industry	
212	od with	Com	12	. • •	Cross	sing Guar			A.A. Poli	ce Dept.	
Maryland	ntat Hy ed oth	Be	17. Father's Name (First, Middle, Last)			:	18. Mother's Name	,			
ž	should id Mer mark metic	2	Robert Waters  19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	n Address (Street a	Patrici and Number or Rura	a Hickey		Zin Code)	
	nd 2 salth ar 27 is ir treu			sband			bor S., I				
ore,	of Head of Head fitem r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem	20b. Place ceme	e of Dispos etery, crem	sition (Name of latory or other place	e) D		0c. Location - City		
Baltimore,	Pag tment tent: I jury o		' 4 ☐Donation 5 ☐ Other (Specify)	Oval IIOIII State	of He	eaven Cem	12/2/			ing, Maryland	
Ball	permit Depar Impor any in	(	21 Sign tu of Funeral Service Licensee	d		Name and Addres			eral Home irel, Mar	, Inc. yland 20707	
Ι.			23a. Part1. Enter the disease, or complicat shock, or heart-failure. List only one of	ions that caused the death. [cause on each line.	Do not ente	or the mode of dying	g, such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a Due to (or as a csequence of):								
þ	Examiner		1/5								
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequen	ce of):		VN 1				
\	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	6						
68760,	ficate be executed g physician and is the burial-transit	al E									
687		edical	d						1		
.O. Box	The law requires that the death certifute has been signed by the attending vage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ★ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)					23d. Date of o Month	delivery Day Year	
<u>a</u>	res that igned b be deta	by Pr	Part II. Other significant conditions contrib	outing to death but not resulting	g in the un	derlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?	
rds	w require been sig should b							1 ☐ Yes	2 <b>X</b> No 3□	Probably 4 Unknown	
Vital Records,	The law ra ate has be page 2 sh	Completed						24a. Was an autopsy performe	prior t death		
Vita	icien: certific ector,	Be	25. Was case referred to medical examiner?	nital:		Otho	26. Place of Death				
of	Phys r this ral dir	- T	X 192 5 140	1 □ Inpatient 2 □ EH	Outpatient b. Time of		4   Nursing Hon	ne 5 🗆 Residen 8d. Describe how		pecify) at scene	
Division	nding th. :: After	Certification:	1 ☐ Natural 5 ☐ Pending 2 ☑ Accident investigation	(Month Day Year)	Injury	28c. Injury Work 2 M 1 □ Y			ute involved	1 in calling	
Vis	r Atte	tifica	3 Suicide 6 Could not be	28e. Place of Injury - At home building, etc. (Specify)	-	et, factory, office		Rf Location /Stro		Rural Route Number,	
	urs aft ral Di				STUPPT			HUMBER CE	while, Elapse	WILL, MIZ	
	To the Hospital or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier  (Check only one)  1 ☐ Certifying Physici.  2 ☑ Medical Examiner.	<ul><li>an: To the best of my knowled</li><li>On the basis of examination and manner stated.</li></ul>	dge, death and/or inv	occurred at the tim estigation, in my op	e, date and place, a pinion, death occurre	nd due to the cau d at the time, dat	isə(s) and manner e and place, and d	as stated. ue to the cause(s)	
	To the within To the comp	Σ	29b. Signature and title of certifier	1 1.1		29c. License	number	!	d. Date signed (Mo	•	
	0		) M	1. 1		OCME		No	ovember 2	28, 2004	
	12		30. Name and address of per who comp	leted cause of death (Item 23	a) (Type, F	111 Per	nn Street	Baltim	ore, Mary	rland 21201	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	4						
	Registr		DEC 0 1 2004	Basera	P	Spork	2				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 20b per fb 9838 12-16-04 by Health and Mental Hygiene. Certificate of Death Rag. No:-2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** SINK DARYL KEITH 22 NOVEMBER 2004 6:55A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ANNE ARUNDEL 10 REIGLE COURT ODENTON If Under 1 Year Months Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. 1<del>∏</del>M 2□F 66 Yrs. Director 30 1948 MICHIGAN 369-48-0555 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-1 show the Medical Examiner roust be notified at 1 Yes 2 No MD ANNE ARUNDEL ODENTON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21113 U.S.A. 10 REIGLE COURT Funeral 12. Was Decedent Ever in U.S. Anned Forces? 1 Payes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) PHYSICIST MEDICAL other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be fil ment of Health and Mental H tant: If item 27 Is marked ott jury or other traumatic even and Mental ! MARTHA PATZER CLIFTON E. SINK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ANDREW SINK/ SON 10 REIGLE CT. ODENTON, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 14 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) BALT.-WASH.-CREMATORY 12-4-04 LAUREL, MD 22. Name and Address of Facility FLECK FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee OU ward 7601 SANDY SPRING RD. LAUREL, MD 20707 23a. Part 19 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEARS **Physician** CEREBROVASCULAR ACCIDENT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached o 9 Unknown 9 Unknown ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by HYPERTENSION, DIABETES 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 No 1 Tyes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 A Residence 6 Other (Specify) ို 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No investigation within 24 hours efter death. To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Referritions Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier MD 31454 DECEMBER 1, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6900 GEORGIA AVE. N.W. WDC, 20307 RUSSELL DAVIS, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 1 2004

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene JH 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 10:00 AM NOVEMBER 24 DOROTHY SULZBACHER 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL HOWARD FULTON 8527 CLARKSON DRIVE 5. Social Security Number 7. Age (In yrs. last birthday, 91 Yrs. If Under 1 Year Months Days If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 ☐ M 2 🖾 F 218-82-1878 Director SEP.20, 1913 PENNSYLVANIA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Items 23a or 28a-f ehoviner plust be notified at HOWARD 1 ☐ Yes 2 ☐ No MD ANNE ARUNDEL FULTON Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 8527 CLARKSON DRIVE 20759 U.S.A.

14. Race - American Indian, Black, White, etc. death Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ir then "natural", or items 11. Marital Status Pages 1 and 2 should be filed within 72 hours after cannot of Health and Mertal Hygiene.
ent: if item 27 is marked other then "natural; or flee
ury or other traumatic event, the Medical Exemines 1 □Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ۵ WHITE 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) TEACHER ELEMENTARY SCHOOL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE MAKARA MARY "UNKNOWN" မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LOUIS SULZBACHER/SON 8527 CLARKSON DR. FULTON, MD 20.759 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If its any injury or ot once. 1 ☐ Burial 2 XCremation 3 ☐ Removal from State BALT.-WASH.- CREMATORY11-30-04 4 ☐ Donation 5 ☐ Other (Specify) LAUREL, MD permit. 22. Name and Address of Facility FLECK FUNERAL HOME, INC. Signature of Funeral Service L 7601 SANDY SPRING RD. LAUREL, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failwe. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA -ALZHEIMERS TYPE **Physician** YEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit P.O. Box 68760, Due to (or as a consequence of) physician Physician/Medical IF FEMALE: USB 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ğ in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but/not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2X No Be 25. Was case examiner? ferred to medical 26. Place of Death (Check only one) Hospital: Other: မ 1 🗌 Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Certification; After s after dec. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOVEMBER 29, who completed cal se of death (Item 23a) (Type, Print)  $ec{m{\vee}}$ 7350 VAN DUSEN RD # 320 LAUREL, MD 20707 DOBYNS, MARIE A. 32/Registrar's Signature State souls. Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ne. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Joy Eleanor Snell 29 JOOH November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number Pital osedale 1 Year | If Under 24 Hrs. vare oaltimore 6. Sex ge (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Davs 1 ☐ M 2 🔀 F Months Hours 212 36 2888 Director April 24,1927 Nova Scotia Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or Itams 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location or Itams 23a or 28a-f show 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Director Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1709 Cape May Rd. 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ☐ Yes 2 XNo f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ss 1 and 2 should be filed within 72 hours a of Health and Mental Hygiene. item 27 Is marked other than "neturel, or other traumatic event, Ite Madical Exertications. 1 ☐ Yes 2 X No Specify: þ Specify: White 3 XWidowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Deadder Lillian Coffill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 Is any injury or other trav Terry Snell (Son) 5245 Autumn Field Ct. Ellicott City, Md. 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith 12/2/2004 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, 21. Signature of Funeral Service Licensee 23a. (alf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Year Month Dav 4 Pregnant at time of death 5 Other (specify) the a detached 1 Yes 2 XNo 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed holesterolemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' 2□ No 1 ☐ Yes 2 No 1 Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To tha Funaral L 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) November 29 2004 mo Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Dr. Eric Vager 32. Registrar's Signature State DEC 0 1 2004 Senera Registrar

ORIGINAL LOCK

		1 - For State Registrar	State of Marylar			of He	alth an	d Me	ental Hyg	iene eg. No 2 (	004	3793
Physici: /Medic		1. Decedent's Name (First, Middle, Las Margarete Elisal	oeth Schnaack						2. Date of Deal Month Novemb	Day	Year 2004	3. Time of Death 7:00 a M
Examin	er	4a. Facility Name (If not institution, give Renaissance Gard	•		4b. City, T		ocation of 0	eath		4c. Cour	nty of Death	
Funeral Director		5. Social Security Number 6. State 215–80–7473  Usual Residence of Decedent	ex 7. Age ( <i>lin yr</i> s. □M 2 <b>X</b> F 90	last birthday) Yrs.	If Under 1	Year	f Under 24	vlin.	Date of Birth (Month, Day, Peb 19,	Year)	9. Birthp Coun	lace (State or Foreig try) nany
death with the Maryland ms 23a or 28e-f ehow fraust be notified at	ctor	10a. State 10b. County Maryland Baltimon		ty, Town or Lo	sville	:			-		1	0d. Inside City Limits
h with th	Funeral Director	10e. Street and Number 709 Maiden Choice	e Lane		10f. Zip 0	228			1		ted St	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other then, natural; or items 23a or 28e-1 ehow any injury or other traumatic event, the Medical Examinar must be notified at once.		11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  15. Decedent's Ed	12. Was Decedent Ever in U Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	82	Was Decede If Yes, specif 1 Yes 2	No .	Specify:	? (Speci uerto Ri	fy Yes or No- can, etc.)	Spec		ite
ad within 72 giene. er then "na	Completed by	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work DO NOT use memake	done dur retired)	ing most of	working			Business/Inc	,
nd 2 should be filed lth and Mental Hyg 27 is marked other traumatic event,	To Be C	17. Father's Name (First, Middle, Last) Otto Tempel			nemane		_		First, Middle, M Heppner	faiden Suma		
es 1 and 2 sho of Health and litem 27 is m		19a. Informant's Name/Relationship (7 Ulrich Schnaack / 20a. Method of Disposition	Son 20b. F		Lindy	Road	, Seve	en V	e 2	. Penn		ia 17360
permit. Pages 1 a Department of Hea Important: If Item any injury or othe		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	) Ba	ayview 22	Cremat	Cory Address	of Facility	Hub	bard Fu	meral	Home,	Maryland Inc. nd 21229
Physician /Medical Examiner	al Examiner	23a. Part1. Enter the disease, or composition, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Little Unidenying Cause (Disease or injury that initiated events resulting in death) Last	a. Atheroscle: Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	rotic ( quence of):						st,		Approximate interval Between Onset and Death 4 years
ath certific stending p or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregns 1  Live birth 2  Feta 4 Pregnant at time of d	Ideath 3	Ectopic preg						ate of deliver	y Day Year
w requires that the de been signed by the e should be detached to	ρ	Part II. Other significant conditions co	ntributing to death but not res	ulting in the ur	nderlying cau	se given i	n Part I.					cause of death?
The law requires to the law requires to the law been signed page 2 should be contact.	Completed							-	24a. Was an autopsy perform		prior to com death?	sy findings available pletion of cause of
ttending Physician: Th death. stor: After this certificate / the funeral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury		Other: Injury at Work?		g Home	5 Resider	) ice 6 Oti	her (Specify)	A
he Hospitei or Attending n 24 hours after death. he Funeral Director: Afte pletely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, o	ffice		28f.	Location (Stre City or Town,	et and Num. State)	ber or Rural	Route Number,
Hospi 4 hou Funer ely fill	edical	29a. Certifier (Check only one) 1 € Certifying Phy 2 ☐ Medical Exami	sician: To the best of my kno ner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at estigation, in	the time, o	date and place on, death or	ace, and	due to the cau at the time, dat	ise(s) and m e and place,	anner as sta and due to t	ted. he cause(s)
To the within 2.  To the complet	Σ	29b. Signature and title of certifier	n no		1	icense nu	700	40		d. Date signe	ed (Month, D	ay, Year)
10		30. Name and address of person who con James Evans, MD 70				onsvi	lle.	Mary	land 2	1228		
Stat Registra	e	31. Date filed (Month, Day, Year) <b>DEC 0 1</b> 2004	32. Registrar's Signa	tura	boards							

State of Maryland / Department of Health and Mental Hygiene ()	3

1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 27 2004 10:30 A M SOPEL Physician DEBRA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE CITY JOHNS HOPKINS BAYVIEW HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 KF ,1951 53 Maryland Director 217-56-5773 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or Items 23s or 28s-1 show traumatic event, the Medical Evantra marke rightled at Md. Baltimore Baltimore 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 606 46th Street USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Banquet Server Marriott 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be f and Mental F (unknown) Ronald Monroe Jane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sl ment of Health and ant: If item 27 lar Richard Sopel (husband) 606 46th Street Baltimore, Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o Name 

Burial 2 Cremation 3 Removal from State Holly Hill Mem Gar 12/2/04 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilikaczorowski Funeral Home, PA 21. Signature of Funeral Service License te 1201 Dundalk Ave. Baltimore, Md.21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SUBARALHNOID **Physician** HEMORRHAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3 My NOVEMBER 27, 2004 4940 EASTERN AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) JOHNS HOPKINS BAYVIEW MEDICAL CENTER/ BALTIMORE, MARYLAND 21224 Cathleen F. Masill 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 1 2004 Registrar

	State of Maryland  1- For Amend Item 6&10d per fh G83	/ Department of Health and M 8 12-1-04 tas Certificate of Death	ental Hygiene 004 37936
Physicia	O L KOME.	SCHEVKER	2. Date of Death Month Day Year  3. Time of Death Year
/Medica Examine	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Sina Hospital of Baltimo		N/A
Funeral Director	5. Social Security Number 6. Sex 124 - 22 - 9755 7. Age (In yrs. last 214 - 22 - 9755 76	birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)  11/18/1928  9. Birthplace (State or Foreign Country)  MD
nylanc how		own or Location	10d. Inside City Limits
ufer death with the Maryland in terms 236 or 286-f show riner must be notified at	MD N/A BALT	TIMORE	1 <b>X</b> es <u>3</u> No
with the or 2	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
death with ms 23e or	3601 FORDS LANE , APT. 121  11. Marital Status 12. Was Decedent Ever in U.S.	21215	U.S.A. cify Yes or No- 14. Race - American Indian,
urs a	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☐ No Specify:	Black, White, etc.  Specify: WHITE
ed within 72 hours ygiene. ner then "neturel; it, I're Mudical Ex-	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of workin	16b. Kind of Business/Industry
within 72 ene. then "nel	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)  CONTRACTOR	FLECTRICAL
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John July De filk Mental Hy Ked oth tic event		EVKER RUTH	COLLECTOR
ie, Mea, yle t and 2 should Health and Men tiem 27 is marke other treumatic		9b. Mailing Address (Street and Number or Rura)	
and and lealth m 27 her tr	CHARLES SCHEVKER / SON	176 ARCHIMEDES COURT I	
0 0	1 A Burial 2 Cremation 3 Removal from State	etery, crematory or other place)	20c. Location - City or Town, State
partill Pages permit. Pages Department of Importent: If it any injury or o	' 4 □Donation 5 □Other (Specify) MIKRU  21. Signature Funeral Service Licenses	KODESH BETH ISRAEL 11/:	
Departing Department of the partment  1	30L	LEVINSON & BROS., INC. DAD - PIKESVILLE, MD 21208	
Physician /Medical	23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequential consequen	on not enter the mode of dying, such as cardiac or	respiratory arrest,  Approximate Interval Between Onset and Death
certificate be executed executed is a set the burial-transit is a set the burial-transit in the burial-transit	d		
death e atter	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. II yes, outcome ol pregnancy 1 ☐ Live birth 2 ☐ Fetal dei 4 ☐ Pregnant at time ol death	ath 3 □Ectopic pregnancy	23d. Date of delivery Month Day Year
law requires that the as been signed by the 2 should be detache	Part II. Other significant continuous continuous to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown
The lay		pred	24a. Was an autopsy autopsy performed?  1 Yes 2 1 10 Ye
Physicien: T	examiner?	26. Place of Death Other: 4 Death	
ng Phy Ifter this Ineral d	1 Department 2 EH/	Odipatient 3 DOA 4 Intersing Home	e 5 Residence 6 Other (Specify)  Id. Describe how injury occurred
To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After t completely filled in by the funerel Medical Certification:			of. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	29a. Certifier 1 Certifying Physician: To the best of my knowled (Check only one) 2 Medical Examiner: On the basis of examination and manner state)	dge, death occurred at the time, date and place, an and/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated.  I at the time, date and place, and due to the cause(s)
o the oithin 2 on the omplei		29c. License number	29d. Date signed (Month, Day, Year)
F S F O	I dhomas of MO		
10-1	Name and address of person who completed cause of death (Item 23)	a) (Type, Print)	movembe as and
101	Janama Ahmad	MO. Sinas Hos	pital of Baltimore
State Registrar	31. Date filed (Month, Day, Year) DEC 0 1 2004  33. Registrar's Signature	5 sports	

John William Storrer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-07585 State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 1&Unpend Item 23a&27 per me G839 1-14-05 tas Reg. No. Reg. No. cm 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 25, 2004 **Physician** 12:20 PM John William Storrer Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Parkville
If Under 1 Year | If Under 24 Hrs. 2510 Hillford Road Baltimore 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 € M 2 □ F 217-64-4181 50 Yrs Director July 1, 1954 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or Items 23e or 28e-f show other traumatic event, the Nedical Exemenations for notified at MD Baltimore 1 ☐ Yes ⅔☐No Carney Director 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 2510 Hillford Drive 21234 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural, or Item any injury or other traumatic event, the Medicul Examples Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Draftsman Civil Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John William Storrer Sr. Catherine Eck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Ann Burkefree Storrer 2510 Hillford Drive Carney, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/29/04 Immanuel Lutheran Baltimore, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility  $exttt{Miller-Dippel Funeral Home Inc.}$ 21. Signature of Funeral Service License 6415 Belair Road Baltimore, Maryland 21206 m 23a. Part1. Enter the disease, or shock, or heart failure. Line Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death fications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a. Atherosclerotic Cardiovascular Disease Physician /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Ulnknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2□ No Hospital or Attending Physician: 25. Was case referred to medical examiner?

Yes 2 \sum No director Be 26. Place of Death (Check only one) Hospital: Other:  $_{4}$  Nursing Home  $_{5}$  Residence  $_{6}$  Nother (Specify) at scene 0 1 Inpatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: Natural Accident 5 Pending investigation M 1 ☐ Yes 2 ☐ No death. s after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funaral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) th e 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 MW O.C.M.E. November 26, 2004 Uwite 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARGARITO 111 Penn Street, Baltimore, Maryland 21201 KURSU 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year November 30, 2004 **Physician** 12:15 AM Tippett Helen Lorraine /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Dec. 16, 1 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2XF Yrs. Virginia 1923 Director 80 218-20-6062 Usual Residence of Decedent Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State item 27 is marked other then "neturel", or items 23a or 28e-f show other treumatic event, the Madical Examination to inclined at 1 ☐ Yes 2 No Director Towson MD Baltimore he 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 United States 1120 Cowpens Ave Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ **X**No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2000 Specify Specify. White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within nd Menta! Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Delyahia L. Porter Edward D. Bunn 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21284 Carl Trippett/husband PO Box 19135, Towson, Maryland If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 12/04/2004 1 YBurial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem. Gardens Timonium, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service License Ruck Towson Funeral Home, Inc. Stephen Coster 1050 York Road, Towson, MD 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DAncreatic month **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has e 2 autopsy performed? 1 Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; After Hospitel or Attending 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the the within : 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier No venber 30, 200k 025205 no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 Baltimore, MD. 6601 N. Charles Street Rile 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 01 2004 Registrar

DHMH 17 Rev 1/2001

Sen Tippett

ORIGINAL

State of Maryland / Department of Health and Mental Hygien \( \cap \cap \) 37939

		Amend Item 1 per	me G840 2-16-	05 Certificate	of Death	Reg. N	2004 10.	01000	
	Physician /Medical	1. Decedent's Name (First, Middle, Last) Saul Mayor Saul M. Tor				2. Dete of Death Month NOVEMBER	23, 2004	3. Time of Death 1:55 P	
	Examiner	4a Fecility Neme (If not institution, give s REAR OF 784-B CEN	street end number)		4b. City, Town, or Loc EDGEWATER	?	c. County of Death ANNE ARUN	NDEL CO	
	Funeral Director	unk.	7. Age (In yrs. i	last birthday) If Under 1 Yrs. Months D	ear If Under 24 Hrs. eys Hours Min.	8. Date of Birth (Month, Day, Yea 12–9–1973	9. Birthp Cour El S	place (State or Foreign htry) alvador	
	faryland show	Usuel Residence of Decedent  10a. State 10b. County		y, Town or Location			10d. Inside City Limits 1 ☐ Yes 2X No		
	a or 28s-f sl	Maryland   Anne Arur  10e. Street end Number  784-B Central Aver		Edgewater 10f. Zip Co 210		10g. C	Citizen of What Cour		
020	d.2 should be filed within 72 hours after death with the Maryland h and Mantal Hygiene.  7 is marked other than "natural; or items 23a or 23a-f show traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Merital Status 1 ☐ Never Married 2 🛣 Married	12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		of Hispanic Origin? (Spe Cuban, Mexican, Puerto F No Specify: El S		14. Race - Americ Black, White, Specify: Wh.		
Maryland 21215-0020	ed within 72 hours a ygiene.  Per than "natural", of it, the Medical Exart.  Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 6th	cation completed) College (1-4or 5+)	16e. Decedent's Usual O (Give kind of work d life. DO NOT use n Delivery Dr	one during most of workin stired)	16b.	Kind of Business/Ind		
bu	2 should be filed with and Mental Hygiene. Is marked other than raumatic event, the M To Be Comp	17. Father's Name (First, Middle, Last)		•		(First, Middle, Maide			
ylaı	should be and Mental and Mental or unartic eve	Ramon Leand	iro Mayorga		Juan	a Torres			
Jar	2 sho and is me	19a. Informent's Name/Relationship (Ty)	ре, Print)	Townservestives of	reet and Number or Rure				
Baltimore, A	es t and of Haali	Alaric B. Anthony  20a. Method of Disposition  1 Burial 2 Cremation 3 AR  4 Donation 5 Other (Specify)	emoval from State	115 Oakford lace of Disposition (Name of emetery, crematory or other teon Nueva Co	place)	Date 20c.	Location - City or To	037 own, State an Salvador	
Baltir	permit. Peg Dapartment important: I any injury o pnce.	21. Signature of Funeral Service License	[ ]	22. Name and A		orge P. Ka	alas Fune	ral Home	
	THE STATE OF	23a. Pert1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death	n. Do not enter the mode of	dying, such as cardiac or	respiratory arrest,		Approximate Interval Between	
	Physician /Medical Examiner		Chest and					Onset and Death	
/	n and ial-transit	Sequentially list conditions,	. — Due to (of	las a consequence of).					
68760,	The law requires that the death certificete be executed ate has been signed by the ettending physician and paga 2 should be dateched for usa as the bunal-transit completed by Physician/Medical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequence of):			1		
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P.O. B	that the death ce ted by the ettendi dateched for use y Physician/	Part II. Other significant conditions conf	ributing to death but not resu	ulting in the underlying cause	e given in Part I.			the cause of death?	
	v requiras tha been signed should be da leted by F					24a. Was an aut performed?	ava	ere autopsy findings ailable prior to	
of Vital Records,	The law require rate has been si paga 2 should Completed					1 Yes	of	mpletion of cause death? ĜYes 2□ No	
ita		25. Wes cese referred to medicel examiner?			26. Place of Death	(Check only one)	,		
<u></u>	S c direction	10XYes 2□ No		ER/Outpatient 3 DOA		e 5 Residence		W SCENE	
Division o	tal or Attending Ph is efter death. all Director: After the lad in by the funeral Certification:	27. Menner of Deeth 1 □ Natural 5 □ Pending 2 ☒ Accident investigetion 3 □ Suicide 6 □ Could not be	28a. Date of Injury (Month, Dey Year)	13:20 M	Work? 1MYes 2 □ No	8d. Describe how inj	reargate		
Divi	To the Hospital or Attending is within 24 hours efter death. To the Funeral Director: Atter completaly filled in by the funeral Medical Certification:	4 Homicide determined	building, etc. (Specify	street	c	putral Ave	, Edgewat	184-13 4r IMD	
	vithin 24 hours e within 24 hours e To the Funeral D completely filled i	(Check only 2 Medical Examin	ician: To the best of my know er: On the basis of exeminati end manner stated.	ion and/or investigation, in r	ny opinion, death occurre	d at the time, date ar	s) and manner es st nd place, and due to tate signed (Month,	the cause(s)	
D	or view	29b. Signature and title of certifier  Town: Wille	e den	29c. Li	O C M E		/EMBER 24		
	7	30. Name and eddress of person who con	npleted ceuse of death (Item	23e) (Type, Print) 111	Penn Street	t, Baltimo	ore, Maryl	and 21201	
	State	31. Date filed (Month, Day, Year)	32. Registrer's Signat	ture					

Registrar DHMH 16 Rev 6/95

DEC 0 1 2004

32. Begistrer's Signature

DEC 0 1 2004

04 - 7577State of Maryland / Department of Health and Mental Hygien [ ] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Thompson Diane NOVEMBER 2004 10:20a /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 2509 LINDEN AVENUE BALTIMORE CITY Date of Birth (Month, Day, 1-12- Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5 Social Security Number Funeral Months 1 □ M 2X F Yrs. Ala. 53 Director 418-76-9504 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show other treumatic svent, the Medical Examinar must be notified at 1 Yes 2 □ No Director Baltimore NA Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ 21217 USA Apt. B 2509 Linden Ave. or Items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Importent: If itam 27 is marked other then "natural", or Items 23a any injury or other treumatic event, Ita Medical Examinations. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1

Never Married 2 ☐ Married 1 ☐ Yes 2 🖺 No Black Baltimore, Maryland 21215-0036 Specify Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Personnel Plus Caterer 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thompson Armantha Thompson James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21234 6620 English Oak Rd. Apt. 1, Parkville, Md. Cedric Thompson 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of 20a, Method of Disposition 1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) cemetery, crematory or other place) Myrtlewood, Alabama 12-4-04 Cloverhill Cem. 22. Name and Address of Facility Baltimore, Md. 21202 21. Signature of Funeral Service Licensee lady الأص 1101 E. North Ave. March F.H. East y 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final therosc Jevo avd iovascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 XUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 Minknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No director, page 2 1 Yes 2 X No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) SCENE 2 1 XYes 2 No After this Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 2 No 1 Yes death. after death Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier OCME NOVEMBER 26, 2004 M 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

DEC 0 1 2004

			00-4-		epartment of Health a	and Mental Hy	giene 2001 3791 1
			Registrar AMEND TTEM #  1. Decedent's Name (First, Middle, Last)	20b&c PERFH G838	12/07/04 JH	2. Date of De	Reg. No. 3. Time of Death
	Physici /Medic		JAMES	TAYLOR		NOVE	48ER 23, 2004 3:15 PM
	Examin		4a. Facility Name (If not institution, give si	Hospital	Randall	stown	4c. County of Death  Baltimore
	Funeral Director		5. Social Security Number 6. Sex 1212 - 42-0263	M 2 F	hday) If Under 1 Year If Under 1 Year Months Days Hours	Min. San Pate of Bi	rth 9. Birthplace (State or Foreign Pay, Year) + Florida
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	the Maryi 28e-f sho	Funeral Director	Maryland Baltin	more Ra	ndallStow.	1	1 1 Yes 2 □ No 10g. Citizen of What Country?
	23a or	rai Dii	4 Spinners	C+.#1A	21133		USA
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If I tem 27 is marked other than "naturel; or items 23a or 28e-f show or other freumatic event, the Marical Examinar must be notified at or other freumatic event, the Marical Examinar must be notified at	by Fune	11. Marital Silatus  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces?  1 Mayes 2 □ No It/Yes, Give Year or Dates:	13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar 1 Yes 2 No Specify:	gin? (Specify Yes or No , Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.  Specify: P. L. A. L.
215-0036	72 hou nature		15. Decedent's Educ (Specify only highest grade	ation 16a.	Decedent's Usual Occupation (Give kind of work done during mos	of working	16b. Kind of Business/Industry
2	filed within Hygiene. Sther than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Salesman		Atlas Supply Co.
land	ould be filed Mental Hygi arked other atic event, I	To Be	17. Father's Name (First, Middle, Last)	Bryant	Is. Motrie	r's Name (First, Middle	a VIOC
Maryland	and 2 should ealth and Men n 27 is marke ler treumatic		19a. Informant's Name/Relationship (Typ	e, Print) (wire) 19b.	Mailing Address (Street and Number Services CH	r or Rural Route Numb	-11-1-12 Md 51120
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 eny Injury or other tre 2008.		20a. Method of Disposition  1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	comotor	Disposition (Name of crematory or other place) ZION CEMETERY	2/7/2004	20c. Location - City or Town, State
Baltir	permit. Pag Department Important: I eny Injury o once.		21. Signature of Funeral Service Aicense	& Rum	22. Name and Address of Facility Joseph L. Rus	s Fuzera	of Home
			23a. Part   Enter the disease, or complice shock, or heart failthe. List only on	ations that caused the death. Do recause on each line.	not enter the mode of dying, such as	cardiac or respiratory	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of	encephacop	4744	Crist and Dodon
(he	Examiner		Sequentially list conditions, b.	CARDIAC	ARREST		
	uted d ansit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	MYOCARD	IN INPARC	-	
90,	icate be executed physician and s the burial-transit	i Exa	resulting in death) Last	Due to (or as a consequence			
68760,	ificate t g physia as the b	edicai	d				
Box	The law requires that the death certific tie has been signed by the attending page 2 should be delached for use as:	Physician/M	in the past 12 months?  1 \( \text{Yes}  2 \subseteq \text{No} \)	ic. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
P.0	that the de led by the a detached f		9 ☐ Unknown  Part II. Other significant conditions con		the underlying cause given in Part I	23e. Did	tobacco use contribute to the cause of death?
ords	w requires been sign should be	ted by	HTN ; ESI	ed; gerd		10	Yes 2 No 3 Probably 4 □Unknown
Records,		Completed				24a. Was auto perf 1 🗆 Yes	
Vital	Physiclen: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital: 1 €Inpatient 2 ☐ ER/Ou	Other	of Death (Check only	
of	Phy rald	lon: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28b. 1	ime of piury at Work?  M 1 Yes 2	28d. Describe	idence 6 □Other (Specify) how injury occurred
Division	or Attendition of Att	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)		28f. Location	Street and Number or Rural Route Number, wn, State)
J	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	Medical Ce			, death occurred at the time, date and/or investigation, in my opinion, dea		cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within To the comple	Med	29b. Signature and title of certilie	k Z	29c. License number		29d. Date signed (Month, Day, Year)
	/	77	· IPA	w	D445	: د	November 23, 2004
10	411		30. Name and address of purson who co	P LMP5K14L	Jr.MO -	HWHC	
1	Sta Regist		31. Date filed (Month Per Page) 1 20	32. Registrar's Signature	& Small		

		-	For State Registrar	State of Maryl		artment o				giene Reg. N200L	37942
	Physicia		1. Decedent's Name (First, Middle, Las.	t)					2. Date of De Month	Day Ye	3. Time of Death
	/Medic	al -	Richard K. Ur			# 0't T-			Nov	25 200 4c. County of D	
	Examin	er	4a. Facility Name (If not institution, give	~ 6.1		-	wn, or Locat	tion of Death			we County
	Funeral		5. Social Security Number 6. Se		yrs. last birthday)	If Under 1	ear If Ur	nder 24 Hrs.	8. Date of Bird	th 9.	Birthplace (State or Foreign
	Director		220-22-6514	<b>Z</b> M 2□F	77 Yrs.	Months E	Days Hou	urs Min.	(Month, Da 4/11	/27 MA	RYLAND
	p >		Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or Lo	cation					10d. Inside City Limits
	faryla shov	ō									1 ⊠Yes 2 □ No
	hours after death with the Maryland tural', or Items 23a or 28a-f show al Ezatra net must be medified at	Director	MD N/A	<b>1</b>	BALTIM	10f. Zip Ci	ode			10g. Citizen of What	Country?
	23a or		3025 HUDSON ST	TREET			21224	4		USA	
	ems 3	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Deceden	t of Hispanio	c Origin? (Spe xican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - A Black, W	merican Indian, /hite, etc.
36	or It	by Fu	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give		1⊠Yes 2□		ecity:		Specify:	IIIITTE
21215-0036	72 hours "natural", ulcal Exz		15. Decedent's Ed	Year or Dates:	16a. Dece	dent's Usual (	Occupation			16b. Kind of Busine	WHITE pss/Industry
215		Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work of DO NOT use	done during retired)	most of worki	ng		
213	e filed within the Hygiene. other than vant, the M	Com	11	0	G	ROCER				GROCERY	STORE
pu	should be filed nd Menta! Hygi marked other umatic avant, I	Be	17. Father's Name (First, Middle, Last)	3 T T						, Maiden Sumame)	
ry a	d 2 should th and Men 7 Is marke traumatic	မ	EDMUND URBANS  19a. Informant's Name/Relationship (7		19h Mailir	na Address /S		AMELI <i>a</i> umber or Rura	7	known) er, City or Town, Stat	e. Zip Code)
Maryland	12 ha 7 ls		MRS. RITA A. UF						ΓΙΜΟRΕ		224
	s 1 and 2 if Health Item 27 I	F	20a. Method of Disposition	20	b. Place of Dispo cemetery, crer				Date	20c. Location - City	or Town, State
E	Page:		1 🔀 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Removal from State H	OLY ROS	-		11/29	9/04	DUNDALK	, MD.
Baltimore,	permit. Pages 1 Department of H Important: if Itel any injury or ott		21. Signature of Funeral Service Licen.		/ *	ACZOR	OWSK!	<b>P</b> cilit <b>F'UN</b> I	ERAL H	OME P.A.	01000
-	99 = 29		(Cugue )	Carto						TIMORE,	MD. 21222 Approximate
			shock, or heart failure. List only of						or respiratory a	rrest,	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Metastal  Due to (or as a cor		fate	Cano	res_			Years
	Examiner				isaquarica or).						
	الأسكا	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	sequence of):				-		
V\ <b>&lt;</b>	ocuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
,092	te be executed ysician and ie burial-transit		resulting in death) cast	Due to (or as a cor	isequence or):						
	et e	dicai	•	d							
Box (	eath certifica attending ph for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pro		75-1				23d. Date of	delivery
ñ.	death e atte ed for	icia	in the past 12 months? 1 ☐ Yes 2 No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		∃Ectopic preg ∃Other (s <i>pec</i>				Month	Day Year
P.O.	at the de by the stached	hys	9 Unknown		le de	Or the control		2-11	22a Did t	abassa usa saatabut	e to the cause of death?
S,	ires that signed to d be det	by	Part II. Other significant conditions of	ontributing to death but not	t resulting in the u	nderlying cau	se given in F	-art i.			Probably 4. Unknown
oro	w require been si should I	eted							24a. Was	an 24h Were	autoney findings available
Records,	ne faw has ge 2 s	Completed							autor	rmed?   death	a autopsy findings available to completion of cause of 1? Yes 2 No
tal	ysician: The is certificate hadirector, page	Be Co	25. Was case referred to medical				26. F	Place of Death	1 Yes		res 200 NO
Ξ	Physicia this cert al direct	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA	Other: 4 [	☐ Nursing Ho	me 5 Resi	dence 6 Tother (S	specify) Haspice
0 4	ding Ph After th funeral		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o Injury		. Injury at Work?		28d. Describe	how injury occurred	
Sio	ittendii death. ctor: A ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be		At home form etc.	M	1 🗆 Yes		28f Location /	Street and Number of	Rural Route Number,
Division of Vital	or Attendated after death Diractor: in by the	ərtifi	4 Homicide determined	28e. Place of Injury - building, etc. (Sp		reet, factory, c	mice		City or Tol		Tural House Humbor,
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Diractor: After this certificate has been signed by the attending physician and property filled in by the funeral director, page 2 should be detached for use as it	Medical Certification:	29a. Certifier (Check only one) 1 Certifying Ph	ysicien: To the best of my niner: On the basis of exam and manner stated.	knowledge, deat mination and/or in	h occurred at vestigation, in	the time, da	te and place, , death occurr	and due to the ed at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	omple	Me	29b. Signature and title of certifier			29c. t	icense num	iber		29d. Date signed (M	
	->-0		I form h	Black		-	0061	- (		Nov, 2	5,2004
	/		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)	, -		7		12 - 1
	5	-	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	Char	les >	1 . 1	04504	mo 2	1204
	Sta Regist	até rar	DEC 0 1 20	04 Jener	a B	spo	ester				

OKBANSKI, KRIFAND 11.2504 SIZBAM

			1- State of Maryland / Depa Registrar Cert	tificate of Dooth	· 2001. 2701.2
			Decedent's Name (First, Middle, Last)	2. Date of De	
	Physici		Bradford Chadwick Wallace	Month	Day Year
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	23, 2004 1:30 P M 4c. County of Death
			Ma Maison Assited Living	Perry Hall	Baltimore
г.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min. 8. Date of Bir (Month, Days)	th 9 Birthplace (State or Foreign
	Director		Usual Residence of Decedent	Feb. 10	, 1921 MA
	land ow		10a. State 10b. County 10c. City, Town or Loc	eation	10d. Inside City Limits
	Mary -f sh	to	MD Baltimore Perry Ha	7.1	1 ☐ Yes 2 [X No
	r 28a	Director	MD Baltimore Perry Ha.  10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	h with	O E	9005 Kilbride Road	21236	United States
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. W	/as Decedent of Hispanic Origin? (Specify Yes or No Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian,
9	after or Its		1 ∐ Never Married 2 【 Married   1 【X] Yes 2 ☐ No		
8	ural',	d by	3 Widowed 4 Divorced Year or Dates:	☐ Yes 2 X No Specify:	Specity: White
<u>7</u>	be illed within 72 hours after death with the Maryland ital Hygiene. In the Maryland other than "netural; or Itams 23s or 28s-f show evant, the Medical Exarcinat minst be notified at	Completed	(Specify only highest grade completed) (Give k	ent's Usual Occupation and of work done during most of working	16b. Kind of Business/Industry
12	withir iene. than	du	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired)	_
2	filled Hygi thar int.		17. Father's Name (First, Middle, Last)	redit Manager  18. Mother's Name (First, Middle,	Insurance
an	Mental Mental arkad o	To Be	Irton Ellsmere Wallace		Miller
Maryland 21215-0036	2 should and Men Is marks sumatic	ř		Address (Street and Number or Rural Route Number	
	is 1 and 2 should of Health and Mer fram 27 is marks other traumatic			Kilbride Road, Nottingh	
Baltimore,	of Hei		20a. Method of Disposition 20b. Place of Disposi		20c. Location - City or Town, State
E	permit. Pages Department of I Important: If its any injury or of		T D D G T G T G T G T G T G T G T G T G	Svc. Corp. 11/26/2004	Towson, Maryland
a	permit. Departn Imports any inju		21. Signature of Funeral Service Lightness 22.		son Funeral Home, Inc.
<u>m</u>	88 5 8		S. Coster	1050 York Road Towson M	arvland 2101/
			23a. Part1. Enter the disease, or complications III sused the death. Do not enter shock, or heart failure. List only one cause on sern line.	rthe mode of dying, such as cardiac or respiratory ar	rest, Approximate Interval Between
	Pnysician	Y	Immediate Cause (Final disease or condition	A	Onset and Death
	/Medical Examiner		resulting in death)  Due to onas a commence of):		
	Examine	_	Sequentially list conditions, b.		
	sit 9d	ine	Sequentially list conditions, if any, leading to immediate name. First I have trying. Cause (Disease or injury		3
_	and and Il-trar	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
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687	tificate ig phys as the	edlcal	d		
Вох	death certifi e attending I id for use as	N/W	IF FEMALE: 23b. Was decedent pregnancy 23c. If yes, outcome of pregnancy		23d. Date of delivery
m.	death e atte d for	icla	in the past 12 morans?  1 Ves 2 700 4 Pregnant at time of death 5 10	ctopic pregnancy Other (specify)	Month Day Year
0	the y th	Physiclan/Me	9 Unknown		
S, D	res tha igned be de	by P	Part II. Other significant conditions contributing to death but not resulting in the und	derlying cause given in Part I. 23e. Did to	bacco use contribute to the cause of death?
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ecc	law as b 2 sl	Completed		24a. Was a autop	
	ysiclan: The is certificate hadirector, page	Con		perfor	med? death?
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of	E E =	2	1 ☐ Yes 29 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manne Death 28a. Date of Injury 28b. Time of		
	0 0 0	5	1 ⊌ atural 5 Pending (Month, Day Year) Injury	Work?	ow injury occurred
S	ding h. After funer	=		_M 1 ☐ Yes 2 ☐ No	
a service	Attending Ph death. ctor: After th y the funeral	ficat	3 ☐ Suicide 6 ☐ Could not be 28e Place of Injury - At home, farm, stree	t factory office 28f Location /S	treet and Number or Pural Pouts Number
Division	al or Attending after death. I Diractor: After d in by the fune	ertificati	2 37.0010371	ot, factory, office 28f. Location (S City or Town	treet and Number or Rural Route Number, n, State)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 0 0 4 37944 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month WOODROW WILSON WINES, SR. November 22, 2004 8:20 pm 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Crescent Cities Center Riverdale Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1 X M 2 □ F 213-01-7714 88 August 14. 1916 Virginia Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's 1 X Yes 2 □ No Greenbelt 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 13 P Hillside Road 20770 U.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No 1941 − If Yes, Give Year or Dates: 1945 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Specify: White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) NASA/ Naval College (1-4or 5+) Oridnance Lab Property Manager 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edger Wines Betty Pomeroy 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Gary Schenk - Legal Guardian 5123 Keota Terrace, College Park, MD 20740 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veteran's Cemetery 12/1/2004 Cheltenham, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Ave., Hyattsville, MD 20781 tons 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) · ARTERIOSCUENOTIC CANDIONASCULAR DISEOSE 4-Cars Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? Alzheimeer's Didease 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of deeth? Thyroidism 2 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be determined Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Examiner Box 68760. Division of Vital Records, P.O. Depter or recommend to the continuous effer death.

Uneral Director: After this certificate has been significant or the continuous director, page 2 should To the Hospital or A within 24 hours efter To the Funeral Direct

Physician

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

Director

Funerai

Be Completed by

Department of Health end Mentel Hygiene. Importantly of items 23s or 28s-f show any injury or other traumetic event, the Medical Examiner must be notified at above.

**Physician** /Medical

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Physician/Medical

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Certification: To

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Peges 1 and 2 should be filed within 72 hours efter death with nent of Health end Mentel Hygiene.

Baltimore, Maryland 21215-0020

25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifiei

29b. Signature and title of certifier

29d. Date signed (Month, Dey, Year)

Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

MD 4203 Queensbury Rd Hyattsville MD 20781 31. Dete filed (Month Day 32. Registrer's Signature

Registrar

State

completely filled in by the

				rtment of Health		ntal Hygier	ne				
		Registrament TIEM #8 PER FH G  1. Decedent's Name (First, Middle, Last)	838 12/01/	tificate of Deal	17 2	Reg. I	<del>4 U U 4</del>	3.79 blat			
Physic /Medi		Thelma Catherine Williams			1	Nov. 29,	2004	12:30 P M			
Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location	ion of Death		4c. County of Death				
		2627 Dulany Street  5. Social Security Number   6. Sex   7. Age (	In yrs. last birthday)	Baltimore		. Date of Bin	n/a 1/31/1028	place (State or Foreign			
Funeral Director		1711 175	6 Yrs.	Months Days Hou		(Month, Day, Yea	Date of Bin <b>OCT/31/1928</b> hplace (State or Foreign Month, Day, Year)  Maryland  Maryland				
pu *		Usual Residence of Decedent			10d. Inside City Limits						
Maryla fisho	호	Maryland n/a	Oc. City, Town or Lo  Baltim					1 Yes 2 □ No			
th the or 28a	lrec	10e. Street and Number		10f. Zip Code		10g. (	Citizen of What Cou	untry?			
ath wii	la C	2627 Dulany Street		21223		US	1				
ter de	Funeral Director	11. Marital Status 12. Was Decedent Ev. Armed Forces?  1 Never Married 2 Married 1 Yes 2 JVNo	er in U.S. 13. \	Was Decedent of Hispanic f Yes, specify Cuban, Mex	corigin? (Special cican, Puerto Ric	can, etc.)	14. Race - Amer Black, White				
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e filed e filed other vant,	Be C	17. Father's Name (First, Middle, Last)			lother's Name (i	First, Middle, Maid	en Sumame)				
Maryland 2127 d 2 should be filed withir th and Mental Hygiene. If is marked other then traumatic event, Ita Ma	10	Casper Neubart Barnes				ry Weedo					
Mar d 2 sho d 2 sho th and 7 is m traum		19a. Informant's Name/Relationship (Type, Print)  Richard L. Barnes / Brother		ng Address (Street and Nu almer Avenue							
re, M s 1 and 3 f Health item 27 other tr		20a. Method of Disposition		sition (Name of natory or other place)	Dat		Location - City or 1				
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Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 ia marke any injury or other treumstic any on other treumstic and once.		21. Signatura of Funeral Service Licensee		Name and Address of Fa							
Proyection /Medical Examiner	Examiner	Sequentially list conditions		er the mode of dying, such				Approximate Interval Setween Onset and Death			
death certificate be executed eattending physician and of or use as the burial-transit	edical	Due to (or as a d	consequence of):				god Bara data				
, P.O. Box 68 that the death certificated by the attending placed for use as the detached for use as t	Physiclan/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	Day Year			
ecords, P.O law requires that the as been signed by th	b	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause given in P	art I.	23e. Did tobacc	o use contribute to	the cause of death?			
The The ate h	Completed					24a. Was an autopsy performed	2 prior to death?	topsy findings available ompletion of cause of 2  No			
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To tha within 2 To tha complet	M	29b. Signature and title of certifier  Tonylus Fulls, M	0	29c. License numb	018	29d.	Date signed (Month	n, Day, Year)			
3	}	30. Name and address of person who completed cause of dea	ath (Item 23a) (Type, 342( 3	enson Ave,	Suite	230, -	Bultimos	n, Day, Year)  JOY  Pe, MD 2(227)			
- 100	tate	31. Date filed (Month, Day, Year)  BEC 0 1 2004  32. Registrar	's Signature	Spalsi				•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #10f oer fh G838 Cerificate of Reath 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician OV 2004 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N maro Saltimore aton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1□M 2 F 219-30-823 Usual Residence of Decedent Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Medical Examinar must be notified at 1 Yes 2 No **Funeral Director** Marylana 10e. Street and Number 10g. Citizen of What Country? 101. Zip Code 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗖 No Specify: þ 3XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygene. Important: if item 27 is marked other than "na any injury or other traumatic aven." Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nillams 19a. Informant's Name/Relationship (Type, Print) niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) # 21 Marge 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory 1 Burial 2 ☐ Cremation 3 Removal from State Cemeter 4 □ Donation 5 □ Other (Specify) Name and Address A 21. Signature of Funeral Service/License 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediat Cause (Final disease or condition resulting in death)

a. Constant and Adultess acquiress acquires. Approximate Interval Between Onset and Death **Physician** years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner for use as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physicien Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 🗆 No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Dther: ဥ 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 SNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pendina 1 🗀 Yes 2 🗌 No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 22, 2004 D-40251 elguy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325

DL. OCHANEJ

New Rose Hospital Drive Juite Burnie, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 14 Yeer Month Day **Physician** WASHINGTON UCRETIA vovember 2 2004 /Medical 4b\_City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner (In vrs. last birthday) Number **Funeral** 1 ☐ M 2 🕱 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ral', or itams 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Baltimor Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 V If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. pDO NOT use retired) 27 is marked other than "nature traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked of ပ Tadughter, 19b. Mailing Address (Street and Number or Rural Route Number, City Town, State, Zip Code) 21208 19a. Informant's Name/Relationship (Type, Print) item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Department of Important: If it any injury or o jo 1 Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Joseph 21. Signature of Funeral Service Lansee ss of Facility Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PARRINSONS mmediate cause (Final DISEASE ADVANCED YEARD Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by DISEASE DIADETES MELLON 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 1 NO Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier orthwest Hoppilas Confe completed cause of death (Item 23a) (Type, Print) american (down 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

			For State Registrar		S	tate o	f Maryla	and / Depa			lealth an Death	nd Me	_	giene,	2111	l.	379	48
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	/Medic Examin		4a. Facility Name (If	Josep	h Wil , give stree	ter et and nur	nber)		4b. City,	Town, or	r Location of D		10 v e III D e		County of D		10.45pi	111
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	Funeral Director		5. Social Security Nu 217-38-7		6. Sex 1		7. Age (In y	rs. last birthday) Yrs.	If Under Months		If Under 24 Hours	Min.	8. Date of Bir (Month Da April	th 23° (23°)	1941	Birthp Cour Ba	lace (State or F	oreign
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	th with	Funeral Director	710 Sear	les Rd						212	222			U.S	.A.			
	er des Items	nue	11. Marital Status 1 ☐ Never Marrie	od 0 Marri	12.	Was Dece Armed Fo	edent Ever in rces?	U.S. 13.	Was Deced If Yes, spec	dent of H cify Cuba	lispanic Origin an, Mexican, F	n? (Spec Puerto R	ify Yes or No ican, etc.)	-	14. Race - A Black, W	lmeric Vhite,	an Indian, etc.	
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ylai	should be filed and Mental Hygi is marked other eumetic event.	70		s Wilf		0:0		40. 11.		/5			Kvhlma			-		
Mai	nd 2 sh Ith and 27 is n treun	1	19a. Informant's Na	ne Ebn			-in-1a				and Number o							
Š,	permit. Pages 1 and 2 should be files Department of Health and Mental Hyg Importent: If item 27 is marked othe eny injury or other treumetic event. once.		20a. Method of Disp	osition			20b	. Place of Dispo	osition (Nar	ne of other place	ce)	Da	te		cation - City			
im o	Page ment ( tent: If		1 ☐ Burial 2 ☐			ovai irom	Ba	lto-Was	shingt	on emat	tory 12	2-2-	04	Laur	el, Mo	i.		
Balt	permit. Pag Department Importent: I eny injury o		Bho	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Bradley-Ashton-Matthews Funeral Home, Inc.  23a. Part1. Enter the disease, or complications that caused the deal Do not enter the mode of dying, such as cardiag or respiratory arrest.														
			23a. Part1. Enter th shock, or hear	e disease, or t failure. List	complicationly one c	ons that cause on e	aused the de	Do not en	ter the mod	le of dyin	ow Spring, such as ca	rdiae or	Rd B respiratory a	alto rest,	.,Md.	21	interval betwee	en
	Physician		Immediate Cause (I disease or condition resulting in death)	Final 1	a. E	+X=	ens	IVE S	3M	au	cell	Lu	ing	Car	1005		Onset and Dea	2
	/Medical Examiner		,		(	Due to (	or as a cons	equence of):									0	
	D #	ner	Sequentially list cor if any, leading to im- cause. Enter Under	ilying 🚄	6	Due to	or as a cons	equence of):								Ť		
	be executed ician and burial-transit	Examiner	Cause (Disease or i that initiated events resulting in death) L	njury	c	Due to /	or as a cons	equence of);								1		
8760,	cate be executed by sician and the burial-transit				d		07 43 4 55113	54251100 51).										
0	ortificat ing ph) e as th	Medi	IF FEMALE:															
Box	leath certifica attending ph	Physician/Medical	23b. Was decedent in the past 12 in	months?		1 Live b	come of pred oirth 2  F ant at time o	etal death 3	□Ectopic pr □ Other (sp		,			2	23d. Date of Month	delive	ry Day Yea	ar
P.O.	that the deathed by the atte	hysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown	JNo		9□Unkno								ļ				
	as as	by	Part II. Other signifi	cant condition	ns contrib	uting to de	eath but not i	resulting in the u	inderlying o	ause giv	en in Part I.		· ·				e cause of deat	
ord	w require been si should b	eted	110/11	0410	VV_	1 /	reur	TIOL	1100				1)50				ably 4 □Unk	
Rec	<b>eicien:</b> The law certificate has L irector, page 2 s	Completed											24a. Was autor perfo	rmed?	prior	to cor	osy findings ava npletion of caus	se of
ital	(0 14	Be C	25. Was case referr examiner?	ed to medical							26. Place of	f Death (	1 ☐ Yes Check only o	2 No	1 1 1 1	res	2 No	
) (	Physicien: rthis certificanal director.	မ	1 ☐ Yes 2 🔀		Hosp	וואנו		☐ ER/Outpatie		_	4 🗀 Nulsi		e 5 Resid			Specify	)	
on	ding Phye h. After this funeral di	tlon:	27. Manner of Death 1 Natural 2 ☐ Accident	5 ☐ Pendin investig	g	28a, Date (Moni	or injury th, Day Year,	28b. Time o Injury	M Z	28c. Injun Worl 1 □	yat k? Yes 2∐No		3d. Describe h	now injury	y occurred			
Division of Vital Records,	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 4 Homicide	6 ☐ Could r determ	not be	28e. Place buildi	of Injury - Ang, etc. (Spe	t home, farm, st cify)	reet, factory	, office		28	3f. Location (S City or Tox			r Rura	l Route Number	r,
	spitel		29a. Certifier					nowledge, deat										
	the Ho nin 24 l the Fu ipletely	<b>l</b> edical	one)				asis of exam ner stated.	ination and/or in		-		occurred						
	~	Σ	29b. Signature and	title of certifier	ua	lai	oll	3N ME			e number	06			signed (M			+
	18			1 40	-	0	se of death (I	tem 23a) (Type,	Print)	Ва	Unn	1016	2 , H	0	212	0	42004	
	Sta Registr		31. Date filed (Mont	DEC 0	1 200	32. R	egistrar's Sig		9 19	ba.	Es/							

			1 - State of Maryland / Department of Heal Certificate of Dea	ath	Reg.	2004 37949						
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Charles Richard BOWARD, SR.  4a. Facility Name (If not institution, give street and number) Washington County Hospital  4b. City, Town, or Local Hagerston	ation of Death	ovember	Day Year 3. Time of Death 1055 PM  4c. County of Death Washington						
	Funeral Director			Under 24 Hrs. 8. I ours Min. Oc	Date of Birth (Month, Day, Ye t. 16,19	9. Birthplace (State or Foreign Country) Mary Land						
	Maryland a-f show	tor	10a. State 10b. County 10c. City, Town or Location Maryland Washington Hagerstown			10d. Inside City Limits 1≿⊡XYes 2 ☐ No						
	th with the 23a or 28 181 be not	Funeral Director	10e. Street and Number 1012 Fairview Road 1012 Fairview Road 2174	42	10g.	Citizen of What Country? U.S.A.						
036	u within 72 hours after death with the Maryland liene. than "natural", or Itams 23a or 28a-f show the Madical Exam narmust be notified at	by	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Ever in U.S. Armed Forces?  12. Was Decedent Sever in U.S. Armed Forces?  13. Was Decedent of Hispan If Yes, specify Cuban, Me Year or Dates:  13. Was Decedent of Hispan If Yes, specify Cuban, Me Year or Dates:  14. Was Decedent Fever in U.S. Armed Forces?  15. Was Decedent of Hispan If Yes, specify Cuban, Me Year or Dates:  15. Was Decedent of Hispan If Yes, specify Cuban, Me Year or Dates:  16. Was Decedent of Hispan If Yes, specify Cuban, Me Year or Dates:  17. Was Decedent of Hispan If Yes, specify Cuban, Me Year or Dates:  18. Was Decedent of Hispan If Yes, specify Cuban, Me Yes If Yes, specify Cuban, Me Yes If Yes, Specify Cuban, Me Yes If	nic Origin? (Specify exican, Puerto Rica pecify:	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: White						
Maryland 21215-0036	f within piene. r than "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 0-12  16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) fork lift operat	g most of working		. Kind of Business/Industry						
land	D 00 00	To Be C	17. Father's Name (First, Middle, Last)  Harry Edgar Boward	Mother's Name (Fin Dora	rst, Middle, Maid Dean M:	The state of the s						
Mary	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)  Doris Boward – wife  19b. Mailing Address (Street and Name)  19b. Mailing Address (Street and Name)									
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item 3 any injury or othar once.		20a. Method of Disposition  1 🖾 Burial 2 □ Cremation 3 □ Removal from State  1 □ Cremation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Cedar Lawn Memorial	Novembe 24, 20	r	Location - City or Town, State						
Balt	permit. Departi Importi any inj		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Minnich Funeral Home  415 East Wilson Blvd., Hagerstown, Maryland 217  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate									
8760,	The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate and large 2 should be detached for use as the burial-transit	Jicai Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			yathy 6 months						
.O. Box 6	that the death certifica led by the attending pt detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   9   Unknown   5   Other (specify)   1   1   1   1   1   1   1   1   1			23d. Date of delivery Month Day Year						
<u>α</u>	w requires that i been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in f	Part I.		2 No 3 Probably 4 Unknown						
al Records,		Completed			24a. Was an autopsy performed 1 ☐ Yes 2 ☑							
of Vital	Physician: This certificated director, p	To Be	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Place of Death (Ch		6 ☐ Other (Specify)						
To the state of th												
Q	To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in b.	ledicai Cer	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, da 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	ate and place, and on, death occurred at	due to the cause t the time, date a	e(s) and manner as stated. and place, and due to the cause(s)						
)		Me	29b. Signature and title of certifier  Wahar  29c. License num  54	nber 285	29d. I	Date signed (Month, Day, Year)						
少 人	(Ax)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Default 12931 Ork Aill Are.	Hog. Mc	1 21	742						
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2 2 2004 32. Pegistrar's Signature S. April									

			1 - For Stete Registrar	State of Ma	ryland / D		ent of H	ealth and	Mental Hy	giene	_	37950
	Physic /Medi	cal	Decedent's Name (First, Middle, Land Donald Edward Brown	ophy					2. Date of De Month Nov.	Day	<sup>Year</sup> 2004	3. Time of Death 09:45 A M
	Examii Funeral	ner		Sex 7. Age	(In yrs. last birth	На	gersto	DWN  If Under 24 Hi Hours Mi	rs. 8. Date of Bir	W	County of Dealershing  9. Bir	
	Director		192-28-4136  Usual Residence of Decedent  10a. State 10b. County	1\\ M 2□F \ 6	10c. City, Town	'S.	la Days	Hours Mi	09/03/1	1938		PA  10d. Inside City Limits
	ith the Man or 28a-f sh	Director	MD Washing  10e. Street and Number	ton	Hagers	10f.	Zip Code				zen of What Co	1, Yes 2 No puntry?
036	72 hours after death with the Maryland Insture!; or items 23e or 28e-f show dicel Eventine must be inclined at	Completed by Funeral Director	11.08 Fry Avenue  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	1	13. Was De If Yes, s	21742 cedent of Hi cecify Cuba 2∑No	n, Mexican, Pue	(Specify Yes or No arto Rican, etc.)		4. Race - Ame Black, Whit	
21215-0036	within 72 ho ane. then "netur e Medical i	mpieted	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4or 5-	( <u>(</u>		vork done a use retired,	luring most of w	orking		nd of Business	
ਰ	should be filed and Mental Hygis marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last Michael Brody	4		chani	cal E		ame (First, Middle, dred McQu	Maiden :	,	curing
e, Mary	l and 2 sho fealth and I om 27 is me her traums	•	19a. Informant's Name/Relationship		110	8 Fry	Avenu	nd Number or F 1e, Hage	Bural Route Numberstown,	MD 2	1742	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23e or 28a-f show amy injury or other traumatic event, If a Medical Exercitivat must be inclined an ODGs.		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State									
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. MEMS	Э.	PROST	ode of dying		ac or respiratory ar		J., 12	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed X ten has been signed by the attending physician and 3 age 2 should be detached for use as the burial-transit of	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of)							
P.O. Box 6	that the death certifics ed by the attending pt detached for use as t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 □Ectopic 5 □ Other (				23	3d. Date of deli Month	very Day Year
rds, P.	w requires that been signed by should be deta		Part II. Other significant conditions of	contributing to death but	not resulting in th	e underlying	cause give	n in Part I.	23e. Did to		/	the cause of death?
Vital Records,	Physicien: The law re this certificate has be ral director, page 2 sho	Completed							24a. Was autop perfor	sy	prior to c death?	topsy findings available ompletion of cause of 2 No
=	s certii irecto	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2√2 No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpa	tions of r	0		ath (Check only or			
Division of	ling After uner	ation; To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		e of	28c. Injury Work	4 Li Nursing i	Home SEResid			ify)
	- 0 - 1	Certification:	3 Suicide 6 Could not b	building, etc.	(Specify)				City or Tow	n, State)		ral Route Number,
	To the Hospital o within 24 hours aft To the Funerel Di completely filled in	edicai	29a. Certifier (Check only one)  1 ☐ Certifying Ph  2 ☐ Medicel Exar	ysicien: To the best of niner: On the basis of e and manner state	examination and/o	eath occurre r investigatio	d at the time n, in my opi	e, date and place nion, death occi	e, and due to the durred at the time, o	ause(s) a late and p	nd manner as lace, and due	stated. to the cause(s)
	To t To t	M	29b. Signature and little of certifier	Connor.	no	29	oc. License	number 2/76/	2	29d. Date	signed (Month	, Day, Year) ?
H	15×1		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Ty	pe, Print) W, 84	EVENTA	4 87,	FRESFR	ICK	MO T	21701
	Sta Registr		31. Date filed (Month Per Year) in	2004 32. Radiistrar	's Signature	Sperke		,	FRESER	1		

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Kelly William Busching November ам 12, 2004 8:17 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Montgomery Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** MOM 20F 216-80-8690 44 Director 28, 1960 Indiana Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ 💢 🗸 0 Directo Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Itama 23a 3503 Murdock Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours atter Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ita any injury or other traumatic event, the Medical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1977-81 Specify: White ģ 1 Yes 2 No Specify 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Schools Sheet Metal Mechanic 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Gene Busching 2 Margaret J. Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Gene Busching/Father 3503 Murdock Road, Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 18 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc 21. Signatore of Funeral Service Licensee 5 500 University Blvd, W, Silver Spring, torns MD 20901 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ARREST -ARDIAC **Physician** MINUTES resulting in death) /Medical Due to (or as a consequence of) Examiner DISEASE ARTERY CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certilicate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy detached tor in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X-R/Outpatient 3 DOA 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Atter 5 Pending 1 Matural death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Hospital within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) MI) 50300 November 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGIA AVE, #116, SILVER SPRING, Md 20902 THOMAS J ANTHONY MI 9801 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 15 Registrar

			1 - For State Registrar	State of Mar	-	artment of He			giene Reg. No. 0	4 37952
	Dhuaisi		1. Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death Year
	Physici /Medio		Wayne J.	Brawley,	Jr.			Novemb		004 1:10 A M
	Examir	er	4a. Facility Name (If not institution, give s			4b. City, Town, or L			4c. County of	
	Format		6001 Muncaster Mil  5. Social Security Number 6. Sex		ey House In yrs. last birthday)	Rockvi		8. Date of Birl		gomery
Н	Funeral Director			M 2DE	69 Yrs.		Hours Min.	(Month, Da Dec. 2	y, Year)	9. Birthplace (State or Foreign Country) New York
	pu »		Usual Residence of Decedent  10a. State 10b. County		Oc. City, Town or Lo	nation			0 2501	
	faryla f ehov	ō	Md. Montgo	ı	Gaithe					10d. Inside City Limits 1 ☐ Yes 2 🖼 No
	the N	rect	10e. Street and Number	3		10f. Zip Code			10g. Citizen of W	
	h with	<b>Funeral Director</b>	9509 Huntmaster R	oad			20882			States
	ems (	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Vas Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Sp Mexican, Puerto	ecrfy Yes or No Rican, etc.)		- American Indian,
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes 2 No If Yes, Give Year or Dates:			Specify:	,	Specify:	
9	thour	ed b	15. Decedent's Edu		16a, Deced	lent's Usual Occupation	on		16b. Kind of Bus	
212	hin 72 9. An "ne Medi	piet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done dur OO NOT use retired)	ring most of work	ing		
2	ygieni ygieni ver thi t, Ire	Completed	12	7	Tea	acher				y Schools
and and	be fill hall H ad oth even	Be	17. Father's Name (First, Middle, Last)	Lav. Co					Maiden Sumame	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. Is marked other than "neturel", or Items 23e or 28a-f ehow umatic event, I're Msolical Examiner must be neithed at	으	Wayne J. Braw 19a. Informant's Name/Relationship (Ty.)	0 -	19h Mailin	g Address (Street and	Gertrud			yard
	and 2 s ealth an n 27 is		Linda C. Brawley			Huntmaste			-	
altimore,	of Hez item		20a. Method of Disposition		20b. Place of Dispos	The state of the s	and the same of th	Date		City or Town, State
Ē	Pages ment of l ent: If its ury or o		1 ⊠Burial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)	emoval from State		s Cemetery	11/3	12/04	Germanto	own, Md.
Balt	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other treumatic:		21. Signature of Funeral Service License  Murriy W. B.		22	Name and Address Muriel H.	of Facility Barber   5038	Funeral	Home	1. 20882
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the cause on each line.	e death. Do not ente					Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	End Sta	age Renal	Failure				Onset and Death
3	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):					
		-e	Sequentially list conditions, b	Recurre		ins Diseas	е			
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	le be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a c	consequence of):					
8760	<u>a</u> € €	dicai	d							
9		/Me	IF FEMALE:	3c. If yes, outcome of	oregnancy				00.4 0.44	- f .d - l'
Box	The law requires that the death certifi tte has been signed by the attending tage 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No	1 Live birth 2 [ 4 Pregnant at tir	Fetal death 3	Ectopic pregnancy Other (specify)			Mont	of delivery h Day Year
o.	t the c by the achec	hysi	9 Unknown	9□ Unknown						
s, D	res that the de igned by the a be detached f	by P	Part II. Other significant conditions con	tributing to death but r	not resulting in the un	iderlying cause given	in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
ord	w require been sis				<del></del>			1 🗆 Y	′es 2□No 3	Probably 4 Unknown
Records,	e law i has be	ompieted						24a. Was autop	sv pri	ere autopsy findings available ior to completion of cause of
_		O				<u> </u>		1 ☐ Yes	2. № No 1	ath? ☐Yes 2☐No
Vita	ysicien: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	2 ER/Outpatient		6. Place of Death			(Specify) Hospice
TO C	g Phy er this	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time of	28c. Injury at Work?			ow injury occurred	
Ö	tending I death. tor: After the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(WOTH, Day 1	oar/ Injury		s 2 No			
Division	P o o	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, stre Specify)	et, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	pital cours a meral (		29a. Certifier 12 Certifying Phys	ician: To the best of n	ny knowledge, death	occurred at the time	data and alana	and due to the		
	To the Hospital or within 24 hours after To the Funeral Dii sompletely filled in	edicai	(Check only 2 Medical Examination)	er: On the basis of ex and manner stated	ramination and/or inv	estigation, in my opini	ion, death occurr	ed at the time, o	date and place, an	id due to the cause(s)
	To the vithin to the comp	M	29b. Signature and title of certifier			29c. License n		4	29d. Date signed	(Month, Day, Year)
	15		14-24	$\sim$	N		5635		November	10, 2004
			30. Name and address of person to con Joseph Kaplan, M. D.			<sub>Print)</sub> Philip Driv	ve. Olne	v. Md.	20832	
	Sta	te	31. Date filed (Month, Day, Year)	32, Registrar's	Signature	ø	-, 01110	J ,		
	Registr	- 9	NOV 15 2004	Serva		sparker				

			1 - For State Registrar	State of Mary	-	artment of H			jiene eg. 200	4	3795	53
			1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month		V	3. Time of I	Death
ı	Physici /Medic		Joseph Peter	В	asaman,	Sr.		Novembe		Year 004	10:20	ам
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Dea	th	4c. County o	f Death		
L			15411 Bond Mill			Laure1			Prince			
	Funeral		5. Social Security Number 6. S	☑M 2□F	yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min	. (Month, Day		Count		Foreign
Н	Director	}	Usual Residence of Decedent	8	0	l		Aug. 13,	1924	New	York	
	yland		10a. State 10b. County	10	c. City, Town or Lo	ocation				10	0d. Inside Cit	y Limits
	Mar Mar	to	Maryland Prince	George's	Laure1						1 ☐ Yes	2 <b>-</b> No
	th th	olre.	10e. Street and Number			10f. Zip Code		1	log. Citizen of WI	hat Coun	try?	
	ath w 23a	ral	15411 Bond Mill				20707		USA			
	er de	nue	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14. Race Black	- America , White, e		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No. If Yes, Give Year or Dates:	942 <b>-</b> 1945	1 ☐ Yes 2 🙀 No	Specify:		Specify:		t	
ŏ	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-f show that the Medical Examinar must be medified at	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa			16b. Kind of Bus	Whi siness/Ind		
2	hin 7	ed (	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most of wo	orking				
2	ed wil	Completed		5+	Poli	ce Office			Law Enfo		nent	
n	d oth	Be	17. Father's Name (First, Middle, Last,				18. Mother's Na	me (First, Middle, i	Maiden Sumame	)		
<u>\\ \</u>	Men Marke Marke	၉	Louis Joseph Ba					zzella	Lamer			
a N	12 st h and 7 is n traun	n i	19a. Informant's Name/Relationship (		12529252	ng Address (Street a		12 1001	100000	85W 52	2000	
<u>.</u> ب	1 and Healt em 2	1 3	Eileen T. Basama: 20a. Method of Disposition		20b. Place of Dispo	1 Bond Min sition (Name of		Laurel Date	Marylar 20c. Location - C			
0	ages in of o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif		cernetery, cre Sate of H	matory or other plac eaven						W 8
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat; or frems 23a or 28a-f show may injury or, other traumatic event, the Madical Examinational be notified at once.		21. Signature of Funeral Service Licer		2	<ol><li>Name and Address</li></ol>	ss of Facility	17,2004			ng, Mary	land
ä	Dep Imp		January S	Cooker	F	rancis J. 00 Univer	Collins	s Funeral	Home, ]	inc.	MD 200	an1
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do not en	ter the mode of dyin	g, such as cardia	c or respiratory arr	est,		Approximate Interval Betw	
D	Physician		Immediate Cause (Final disease or condition	***	3						Onset and D	
	/Medical		resulting in death)	a. Hepatoma Due to (or as a co								
	Examiner		Sequentially list conditions,	b								
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence ot):							
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	cDue to (or as a co	onsequence of):							
8760,	sate be executed oblysician and the burial-transit		l	d								
9	g phys as the	Physiclan/Medical										
Box	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as!	M/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		Ectopic pregnancy			23d. Date			
о. В	ed fo	sicia	in the past 12 months?	4☐Pregnant at time 9☐Unknown		Other (specify)			Mont	.n	Day Y	ear
<u>Ч</u>	d by t letach	Phy	9 ☐ Unknown   Part II. Other significant conditions of	ontributing to death but or	at reculting in the .	anderhijes cause sive	on in Dort I	23a Did to	bacco use contrib	bute to th	e cause of de	ath?
S,	ires (f	by	Part II. Other significant conditions	onthibuting to death but hi	ot resulting in the t	indenying cause give	en mranti.				ably 4 ⊟Ui	
Vital Records,	w requir been si should	Completed								loro autor	sy findings a	un labla
Rec	has ge 2	d L						24a. Was a autops perfori	sy pri med? de	for to constant?	npletion of ca	use of
a		e Co	25. Was case referred to medical				OC Place of De	1 Yes		Yes	2 No	
5	ysicie is cert directe	0 8	examiner?	Hospital: 1   Impatient	2 ER/Outpatie	nt 3 DOA Othe	000	ath <i>(Check only on</i> Home 5⊠ Reside		(Specify	·)	
o	g Phy er this eral c	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time o			28d. Describe ho			/	
jo	ath. rr: After	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	n	, injury		Yes 2□No					
Division of	I or Attendated after deatl	Certification:	3 Suicide 6 Could not be determined		- At home, farm, st Specify)	reet, factory, office		28f. Location (Si City or Town	treet and Number n, State)	r or Rural	Route Numb	ΘΓ,
Ω	urs af											
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical		ysician: To the best of m niner: On the basis of exa and manner stated	amination and/or in							
	To the within 2 To the complet	Med	29b. Signature and title of certifier	. /		29c. License	e number	2	9d. Date signed	(Month, [	Day, Year)	
)	⊢ × ⊢ ŏ		1/21	MIC/			F0177			1.0	2021	
	25+1		30. Name and address of person who		n (Item 23a) (Type		53177	N	ovember	12,	2004	
			John M. Wallmar	k, M.D. 97	97 Medic	al Center	Drive	Rockvill	e,Maryla	ınd	20850	
	Sta		31. Date filed ( <i>Month</i> , <i>Day</i> , <i>Year</i> ) <b>NOV</b> 1 5 20	32. Registrar's	Signature	p.			J			
	Registi	ar	MOA T 2 50	04 Sener	10	pocks	1					

			For State Registrar	State of Ma	ryland /	Departmen <i>Certificate</i>			ınd Me		iene		
	Physic /Medi		1. Decedent's Name (First, Middle, La Elsa	Bischof	f					Date of Dear Month DVember	h Z	2004	3 The Steady 10:30 AM
	Exami	ner	4a. Facility Name (If not institution, give	re street and number)		4b. City,	Γο <b>w</b> π, οι	Location of	Death		4c. Cou	inty of Deat	h
			12768 Midwood L				owi	_				ince (	Georges
	Funeral Director		003-32-0034	I M 2 XE	(In yrs. last bi	rthday) If Under Yrs. Months	1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, Aug. 25	Year) 1916		hplace (State or Foreign buntry) Many
	and *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Tow	m or Location							10d. Inside City Limits
	Aanyl f sho	ō	MD Prince	0									1 X Yes 2 No
	the t	Director	MD Prince  10e. Street and Number	Geoges	Bowi	e 10f. Zip	Code			1,1	0g. Citizen	of What Ca	
	or death with the Marylar terns 23e or 28e-f show ar must be rediffed at	٥	12768 Midwood La	3.0			071	5		, ,			unity?
	death ms 2	era	11. Marital Status	12. Was Decedent E	ver in U.S.				in? (Specify	Yes or No-	USA 14. F		ncan Indian,
980	or aft	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 PN If Yes, Give Year or Dates:	0	13. Was Deced		n, Mexican, Specify:	Puerto Ric	an, etc.)	Spe	Black, White	hite
2-0	C) 65 LA	ted	15. Decedent's E (Specify only highest gra	ducation	16a	. Decedent's Usua	Occupa	tion	-4dii-		16b. Kind of	f Business/	Industry
Maryland 21215-0036		Completed	Elementary/Secondary (0-12)	College (1-4or 5-		(Give kind of wor life. DO NOT us Sales Per		) )	or working		D +		
9	e filed within Hygiene. other then	C	17. Father's Name (First, Middle, Last	)		bales fer	SOII	18. Mother	's Name (F	irst, Middle, A		ry Sh	юр
/lan	2 should be and Mental is marked o reumatic eve	To Be	Josef Breitenbu	cher						e Maul		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
lan	2 sho and I is me		19a. Informant's Name/Relationship (	** *		. Mailing Address							(ip Code)
	of Health of Health of Health of Health of Item 27 is rother tree		Marliese R. March 20a. Method of Disposition	n/ Daughter		412 S. I		Street	: Ale				
Baltimore,	90 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Special		cemete	ry, crematory or ot Cremato	ner place ry	1	1/11/	2004		orf,	MD
Bal	permit. Pa Departmen Importent: any injury once.		21. Signature of Funeral Sarvice Line	nsee		22. Name and	Addres	s of Facility 1apol1	Rober s Roa	t E. E	vans vie, M	Funer	al Home
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line	go car	not enter the mode	of dying		ardiac or re				Approximate Interval Between Onset and Death
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence	of):							
8760,	cate be executed physician and the burial-transit	dical Exa	resulting in death) Last	Due to (or as a	consequence	of):							
9	ntifica ng ph	(a) +	IF FEMALE:										
.O. Box	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as it	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death	3 □Ectopic pre 5 □ Other (spe						Date of delivery	very Day Year
Records, P.	w requires that s been signed b should be deta	d by P	Part II. Other significant conditions of		not resulting in		ıse give	n in Part I.		23e. Did toba	. /		the cause of death?
CO	law rec as beer 2 shou	piete							_	24a. Was an		. Were aut	opsy findings available
E Re		Com							_	autopsy perform 1 Yes 2	ed?	prior to death?	ompletion of cause of 2 No
Vital	Physicien: this certificatal director, i	Be	25. Was case referred to medical examiner?				-		of Death (Cl	heck only one	)		
of	si si	2	1 Yes 2 TNo	Hospital:				- India	ing Home	5 Thesider	nce 6 🗆 O	ther (Spec	ify)
Division o	ding After fune	Certification:	27. Manner of Death  1		Year) 28b. 1	Time of 28 njury M	c. Injury Work 1 🗆 Y	at ? es 2 ∐ Ne		Describe how	v injury occi	urred	
Divi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certific	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injur- building, etc.	y - At home, fa (Specify)	rm, street, factory,	office			Location (Stre City or Town,		nber or Rui	al Route Number,
	To the Hospital or A within 24 hours after to the Funeral Directompletely filled in by	Medical	29a. Certifier (Check only one)	ysician: To the best of niner: On the basis of e and manner state	xamination an	, death occurred a d/or investigation, i	the time	e, date and nion, death	place, and occurred a	due to the cat t the time, dat	use(s) and r te and place	nanner as :	stated. to the cause(s)
)	To the within To the comp	M	29b. Signature and title of certifier  Aunth	oryclus	\			number	5	29		ed (Month,	Day, Year)
			30. Name and address of person who Genard CHAM	PHLOUN	Mb	14300	Sall	aul f	Fox lo	me B	umile	my	20715
MINE	Sta Registr	te ar	31. Date filed (Month Oxy Year) 2	2004 32. Sistrar	s Signature	Show	2	,					
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DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10 0 1

37955 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 0500 William C. Nov. 15, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Homestead Manor Denton Caroline If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 11/10/17 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral X** XM 2□ F 219-03-6780 Yrs. 87 **Director** Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f ehow the Medical Examiner must be notified at MD 1 Yes X No Director Caroline Federalsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5404 Smithville Road 21632 United States by Funeral filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 45 - 46 1 Never Married \* Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 le markad othar than ' ury or othar traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) USCG Yard Welder Q 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry С. Bone Matilda Dora Fick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5404 Smithville Rd., Federalsburg, MD21632 Betty Bone/ Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ¥OBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: if any injury or once. Bloomery Cemetery 11/18/04 Federalsburg, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 2000000 gremmon. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Constant of the initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician Box 68760 by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the a o 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, renal insufficiency 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Worknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No after death. | **Director: A**fter this certifics d in by the funeral director, <u>r</u> 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 the ther (Specify) 1 ☐ Yes 2 🚉 🖎 o မ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di 19 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Certifier 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier 29c. License number BUD. D00538 55 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 215 Bloomingdalo Ave Federalsburg NO 21632 Melinda Butter 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 37956 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Physician 24, Mable Louise Bye 2004 Nov. 2:13 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise of Frederick Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 7/15/1924 Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 20XF Yrs. 243-20-3997 Director /15/1924 Robersonville,NO Usual Residence of Decedent death with the Merylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours efter death with the Merylen Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at MD Frederick 1 X Yes 2 No Frederick Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 990 Waterford Drive 21702 US Funerai Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify. White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: à 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk CIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lawrence Sterling Curtis Minnie Bunting Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Donna Beitzel 287 Sawyer Lane, Harpers Ferry, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 11/29/2004 Silver Spring,MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jefferson Chapel Funeral Home PO Box 838, Charles Town, WV Lown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner ettending physicien end for use es the buriel-trensit requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) ed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 25 No 1 ☐ Yes 2 No TI Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1□Yes 25 No Other: 4 Nursing Home 5 Residence 6 Sther (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DQA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: Af 1 Tyes 2 □ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Yeer) 29c. License number 11/24/2004 of death (Item 23a) (Type, Print) 31. Date filed (M 32. Registrar's Signature State 2004 Registrar

			1 - For State Registrar	State of Maryland		rtment of F		Reg	ene . No 2 () ()	4 37957
П	Physici		1. Decedent's Name (First, Middle, Last)	)	C	LARK		2. Date of Death Month		3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)	,		r Location of Death	/ ovem b	4c. County of	
			The Johns Hopki	ins Hospital	/	0.1	nore			
	Funeral Director		5. Social Security Number 6. Security Number 215–19–8246	7. Age (In yrs. la	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You 10-01-19)	ear)	Birthplace (State or Foreign Country)  ALISBURY, MD.
	72 hours after death with the Maryland natural; or Items 23a or 28e-f show Iteal Examinat must be notified at	_	10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits
	n 72 hours after death with the Maryian "natural", or Hems 23s or 28e-f show wilcal Examinar must be notified at	Director	MD WICOMIC	O HEB	RON_	Tay 7: 0.1				1 ☐ Yes 2X No
	3a or	ioi	26224 PORTER MILL	RUVD.		10f. Zip Code		10g	Citizen of Wha	
	death rms 2	Funerai		12. Was Decedent Ever in U.S	6. 13. W	21830 as Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-		American Indian,
36	s aftar , or ite	by Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Tes, specify Cuba ☐ Yes 2☐XNo		rican, etc.)	Specify:	White, etc.
5-0036	tural,	ed b	3 Widowed 4 Divorced			ent's Usual Occup		161		WHITE
215	c * 1	piet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give k	ind of work done of NOT use retired	durina most of work.	ing	o. Kind of Busin	ess/industry
2121	filed withir Hygiene. Ither than	Completed	12	1	POLIC	E OFFICE			W ENFO	RCEMENT
Maryland	d tal	Be	17. Father's Name (First, Middle, Last) BARRY CLARK					(First, Middle, Mai	,	
Ž	2 should be and Menta Is marked aumatic ev	2	19a. Informant's Name/Relationship (Ty)	pe. Print)	19b. Mailing	Address (Street		IN CALLOWA al Route Number, C		te. Zin Code)
	1 and 2: Health ar tem 27 is	1 8	NICOLE CLARK - SPOU					HEBRON, N		
Baltimore,			20a. Method of Disposition 1 🕅 Burial 2 ☐ Cremation 3 ☐ R		ace of Dispos	ition (Name of atory or other place				y or Town, State
ij	permit. Pages Deportment of Important: If it any injury or o		`4 □ Donation 5 □ Other (Specify)	SPR			NS. 11-13		BRON, N	MARYLAND
Bal	Deporting on the control of the cont		21. Signature of Funeral Service License	y Herry	22.	Name and Addres	ss of Facility BOU	NDS FUNER	AL HOME	E, INC.
			23a. Part / Enter the disease, or composition of the composition of th	cations that caused the reath.						TLAND 21804 Approximate
	Physician		Immediate Cause (Final disease or condition	A .		N. A.				Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):	ny				3 months
	LXammer	7	Sequentially list conditions, b	JUSTS O as a conseque	ance of):					2 months
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		31100 017.					
0,	ate be axecuted hysician and the burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):					
8760,	cate be axecuted bhysician and the burial-transit	edicai	d							-
9 x	the death certific y the attending plached for use as t	/Me	IF FEMALE:	3c. If yes, outcome of pregnan	cv				224 D. 14	define
Box	death e atter d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea	death 3□E	ctopic pregnancy Other (specify)			23d. Date of Month	Day Year
P.O.	that the death	hys	9 Unknown	9□ Unknown						
Vital Records, I	sigr sigr d be	by	Part II. Dther significant conditions con	tributing to death but not result	ting in the und	derlying cause give	en in Part I.	23e. Did tobace		e to the cause of death?  Probably 4 Unknown
eco	e law requ has been je 2 shouli	Completed						24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
								performed	2 deat	h?
	ysicien: The is certificate hi director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	ospital:	B/O	Othe	26. Place of Death			
o	무 두 등	n; To	27. Manger of Death	28a. Date of Injury 2	R/Outpatient 28b. Time of	3 DOA 28c. Injury Work	4 ☐ Nursing Hor	me 5 Residence 28d. Describe how is		Specify)
ion	uttending death. ctor; Aft / the fun	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		<br Yes 2 □ No			
Division of	f or Att	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stree	et, factory, office	1	28f. Location (Street City or Town, St	and Number o	r Rural Route Number,
_	Hospite 4 hours Funeral ely fillec	Medical Ce	29a. Certifier (Check only one) 2 Medical Examin	sician: To the best of my knowner: On the basis of examination	ledge, death on and/or inve	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	and due to the cause and at the time, date	e(s) and manne and place, and	r as stated. due to the cause(s)
	To the I within 2: To the I complet	Mec	29b. Signature and title of certifier	and manner stated.						
,	, , , , ,		· /OX	Docorn		RF	5-000	1	nivenilo	8 2004
ž	120		30. Name and a dress of person who con	mpleted cause of death (Item 2	23a) (Type, Pr	rint)	DI		)	onth, Day, Year)  P & 200 4  nd 2128 7
	) [[]	10	Ariel Rad 31. Date filed (Month, Day, Year)	32. Registrar's Signatu	J. 14e	Street	- Balti	more, M	langla	nd 2128/
	Sta Registr		NOV 1 2 200	14 Deneva	2	sporks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1 tem 24a per doc 8845 7-21-05 vt

	1	For State Registrar	State of Maryland		t of Health and I e of Death	vientai Hygier Reg. i	0001	07054
Physicia		Decedent's Name (First, Middle, Last,	CANNON			2. Date of Death	Day Year 6 2004	5. Tinle at Death
/Medica Examine		Ia. Facility Name (If not institution, give		4b. City,	Town, or Location of Deat	h	4c. County of Death	ET
uneral irector	5	Social Security Number 6. Security Number	7. Age (In yrs. las	t birthday) If Under Months	1 Year If Under 24 Hrs Days Hours Min.		ar) Cour	lace (State or Foreig
if items 7 is marked other than "natural", or items 23a or 28e-f show or other treumatic event, the Medical Exeminer must be multified at	rai Director	Joe Street and Number  S179 Byrry B  11, Marital Status	RANCH DRIVE 12. Was Decedent Ever in U.S. Armed Forces?	4			Citizen of What Cour  14. Race - Americ Black, White,	an Indian,
item Z is marked other than "natural", or items 23a other treumatic event, the Medical Exerciner must be	Completed by Fu	1 Never Married A Married 3 Widowed 4 Divorced  15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	1 □ Yes ② No If Yes, Give Year or Dates:  roation e completed)  College (1-4or 5+)	life. DO NOT u	al Occupation ork done during most of wo se retired)		Specify: B	LACK
marked other th	To Be Cor	17. Father's Name (First, Middle, Last)  Color (First, Middle, Last)  19a. Informant's Name/Relationship (T)	LEWIS	MAINTAI		me (First, Middle, Maid RICE U  ural Route Number, Cit	ASHING	TON Code)
Importent: if item 27 is any injury or other treu		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	NOD WIFE 20b. Place Commonweal from State	8119 - Buse of Disposition (Na. etery, crematory or of the large of th	BRANCH Street	ADR Sp Date 200.	Location - City In To	10, 2180 wn, State
		23a. Part1. Enter the disease, or comp shock, or head failure. List only o	licetions that caused the death.	917-LL Do not enter the mod	nd Address of Facility  JABELLA  de of dying, such as cardia  CANCL WO M	ST. SAUS	SMITH F SBURY, M	Approximate Interval Between Onset and Death
hysicia the bur	dicai Examiner	cause (Disease or injury	Due to (or as a consequence)  Due to or as a consequence  Due to (or as a consequence)  Due to (or as a consequence)	nce of):				
by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 □Ectopic p			23d. Date of delive Month	ory Day Year
been signed b should be deta	þ	Part II. Other significant conditions of	entributing to death but not resulti	ng in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute to the	
has Je 2	Completed					24a. Was an autopsy performed 1 Yes 2	prior to co	psy findings availa npletion of cause 2 No
his certific	To Be	T Tes 2000		R/Outpatient 3 □ D	OA Other: 4 Nursing I	ath (Check only one)		nprison 1
ain. rr: After ne funer	Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  5 Pending investigation 6 Could not be determined	(Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No y, office	28f. Location (Street City or Town, St	and Number or Rura	I Route Number,
within 24 hours after de To the Funerel Directo completely filled in by th	Medical Co		rsician: To the best of my knowl iner: On the basis of examinatio and manner stated.					
트트로	Me	29b. Signature and title of certifier	MD	"	c. License number		Date signed (Month,	Day, Year)
To			' ( <i>V</i>	-	DOSO926 VER MD Sporks	'	16/04	

			1 - For State Registrar	State of Marylar	nd / Depa		lealth and N	lental Hvaie	•	37959
	Physici /Medic		1. Decedent's Name (First, Middle Thelma Blan	ch Clark				2. Date of Death	Day Year 20 2004	3. Time of Death 0645 M
	Examir	ner		give street and number)  County Hospita  6. Sex 7. Age (In yrs.		4b. City, Town, or Hagers If Under 1 Year	•	8. Date of Birth	Washing	gton
	Funeral Director		219-78-4116 Usual Residence of Decedent	1□M 2√2F 95	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye NOV • 15, 1	909 M	hplace (State or Foreign untry) D
	the Maryla	ector	MD Washi  10b. County  Washi		ty, Town or Lo Lear S	pring,				10d. Inside City Limits 1 Tyes 2 No
	th with	ai Dir	14431 Mercer	sburg Road		10f. Zip Code 217	22		Citizen of What Co. U.S.A.	untry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinet must be notified at once.	Be Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? ad 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I □ Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural', or itams 23a or 28a-f ehow atto event, the Medical Eventine must be notified at		15. Decedent (Specify only highes Elementary/Secondary (0-12) 8th grade	s Education grade completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired DMEMAKET	luring most of work	ing 16b	Industry CE	
yland	ould be file Mental Hy arked othe	To Be (	17. Father's Name (First, Middle, L David Filmore	Robinson			Mary J	e (First, Middle, Maid ane Fait	h	
	nd 2 shall and 27 is m		19a. Informant's Name/Relationsh William L. C.					al Route Number, Ci Rd. Clea		
altimore,	Pages 1 ament of Hestant: if Item		20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other (Sp	3 □Removal from State S	Place of Dispo cemetery, cren t. Pau	sition (Name of natory or other place 11 Cemet	Nov.24 ery 20	0ate 20c C1	Location - City or 1	1000
Ball	P.O.BOX 310 Clear								uneral	Home, Inc
1000	Pnysician /Medical Examiner	_	Immediate Cause (Final disease or condition resulting in death)	a. ATHERUS  Due to (or as a consequence)	CLENOS		g, such as cardiac (	or respiratory arrest,		proximate Interval Between Onset and Death
3760,	ate be executed hysiclen and he burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the arrying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseq						
.O. Box 6	The law requires that the death centificate be executed tie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	very Day Year
ecords, P	w requires that been signed k should be det	by	Part II. Other significant condition	ns contributing to death but not res	ulting in the ur	derlying cause give	n in Part I.	23e. Did tobacc		the cause of death?
r		Completed						24a. Was an autopsy performed 1 Yes 2	prior to co	opsy findings available ompletion of cause of
Vita	ysician: 1 is certifical director, p	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA Othe	r.	n (Check only one) me 5 - Residence	6 DOther (Cons	. A. (
on of	ng Ph Iter th Ineral	lon: T	27. Manne of Death 1 ■ latural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe how in		ny)
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident investigation inves	ot be	ome, farm, stre		′es 2 □ No	28f. Location (Street City or Town, St	and Number or Rur ate)	ral Route Number,
	the Hospit nin 24 hour the Funera	edical	one)	Physician: To the best of my kno xaminer: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the timestigation, in my op	e, date and place, inion, death occurre	and due to the cause ed at the time, date a	e(s) and manner as s and place, and due t	stated. to the cause(s)
		M	29b. Signature and title of certifier	ho completed cause of leath (Item  32. Registrar's Signa	91cc	29c. License	783	29d. [	Buth Zi	2004
b	H-V		30. Name addardings biperton w Dr Hurwitz	ho completed cluse of teath (Item	n 23a) (Type. [	Point) Point Pois R	d Hag	erstown	Mary	land
	Sta Registr		31. Date filed (Month, Day, Year)	2004 32. Refistrar's Signa	d.	oute:				

State of Maryland / Department of Health and Mental Hygiene 0 0 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Ora Mae Clymer рм 11, 2004 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Nursing & Rehab. Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 1 F Director 097-14-2352 May 30, 1920 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at 1 Yes 2 No Maryland Montgomery Germantown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 13722 Creola Court Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify: 3 ∰Widowed 4 □ Divorced Specify: Black "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than 12 Medical Assistant Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Bradley Payne injury or other traumatic Myra Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lesley Hoffman/Daughter 13722 Creola Court, Germantown, MD 20874 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State November 16 permit. Page Department Important: If any injury or Rural Cemetery \* 4 □ Donation 5 □ Other (Specify) 2004 White Plains, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician iasai.c /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of): Examiner sician and burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 8 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this 27. Manner of Peath 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred or Attending 1 atural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Doc 58597 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8609 21d AVE Suite # 4048 aval, MIT Shahrya Silversping, MD 20910 32. Registrar's Signature 31. Date filed (Month, Day, Year) oakst PROMA NOV 15 2004 Registrar

			1 - For State Registrar	State of Maryland		artment of H tificate of L			giene Reg. No.20	04	37961
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Frances Cave Chapm	an				2. Date of Dea Month Novembe	Day	Year 004	3. Time of Death 8:40am
	Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Deal	th	4c. County	of Death	
		М	7332 Muncaster Mil		- A 6 (-45 -45 )	Derwoo	d If Under 24 Hrs	2 Date of Bird		gome	
	Funeral Director		231-62-4131	7. Age (In yrs. la	Yrs.	Months Days	Hours Min.		y, Year)	9. Birth	place (State or Foreign http) VA.
1	how Int		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
	89-f-8	ecto	Maryland Montgome:	ry Der	wood	T					1 ☐ Yes 2X No
	a or 2	Dir	10e. Street and Number	1 D 1		10f. Zip Code	1150		10g. Citizen of \		
920	permit. Pages I and 2 should be filed within 72 hours after beath with the maryland Department of Health and Mential Hygiene. Insportment of Health and Mential Hygiene. Insportment: If them 27 is marked other then "natural", or items 23s or 28s-f show any injury or other treumatic svent, I'm Meulical Espainer must be notified at once.	by Funeral Director	7332 Muncaster Mi1  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	.L KOAC 2. Was Decedent Ever in U.S Armed Forces? 1 _Yes _2  No If Yes, Give Year or Dates:		20855- Was Decedent of Hi f Yes, specify Cubar I □ Yes 2 X No		Specify Yes or No- to Rican, etc.)	United  14. Race Blace Specify	e - Americk, White,	can Indian,
5	natura		15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occupa kind of work done of	luring most of wa	rking	16b. Kind of Bu		
7	within ane. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	00 NOT use retired, onsultant	)		Food I	ndue	<b>t r</b> v
2 1	Hygi other	Be Co	17. Father's Name (First, Middle, Last)	7	- 00	nsurcanc	18. Mother's Na	me (First, Middle,			LIY
10	Menta Menta arked atic sv	To B	James Fra	nklin Cave				Ze1ma	B1ake		
	h and 7 Is m Ireum		19a. Informant's Name/Relationship (Typ	nuspanu		g Address (Street a					·
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2 4	nent or		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State		tan Crema	1	/9/2004	Alexandı	cia,	Virginia
מו	ermit. Pepartr nporte ny inju		21. Signature of Funeral Service License	% Q O O .		. Name and Addres					tevr odverenske
	40 5 6 0		23a. Part1. Enter the disease, or complic	rations that caused the death		East Dee				cg, M	D. 20877 Approximate
	hysician /Medical Examiner		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.  Metastatic B  Due to (or as a conseque	reast						Interval Between Onset and Death Years
,	are be executed hysicien and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque							
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L 2,	n signed b	by P	Part II. Other significant conditions con-	tributing to death but not result	ting in the ur	nderlying cause give	n in Part I.				ne cause of death?
		Completed						24a. Was autop perfor 1 🗆 Yes	rmed?	Were auto prior to co death?	psy findings available mpletion of cause of
אונס אונס	certificate	Be	25. Was case referred to medical examiner?	ospital:		Otho		ath (Check only or			
	fter this	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatient 2 E	R/Outpatien 28b. Time of Injury	28c. Injury Work	at at	10me 5X Resid	lence 6 Oth		y)
LIVID	to the nospiration Attended by within 24 hours after the Lath hours after death.  To the Lath refugle good after this certified completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tow		er or Rura	N Route Number,
	within 24 hours after to the Funerel Discompletely filled in	edicai (	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my know er: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the time vestigation, in my op	e, date and place inion, death occ	e, and due to the durred at the time, d	cause(s) and ma date and place, a	nner as s and due to	tated. the cause(s)
	within To th comp	Me	29b. Signature and title of certifier			29c. License	number	2	29d. Date signed	(Month,	Day, Year)
	20		I Chuke ly	april			42452		Novembe	r 9,	2004
			30. Name and address of person who con Chitra Rajgopal, M.	V			.# 221.	Rockvil1	le. Mary	1and	20850
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signatu		Sporks		TO DEVITE	,y		
	Registr	ar	NOV 15 200	4 peners	100	pponte					

State of Maryland / Department of Health and Mental Hygiene. 004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month NOVEMBER 16, 7:00 A M MARY LOUISE CALLIS 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 308 WOODLAND DRIVE OAKLAND **GARRETT** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MARCH | 15, 1 9. Birthplace (State or Foreign 1921 WV 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2X F Yrs **Director** 218-16-2988 83 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hyglene. Sther than "natural", or Items 23a or 28a.4 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ? Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 11√ Yes 2 No Directo MD GARRETT OAKLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 308 WOODLAND DRIVE 21550 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE δ Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglenn Importent: if Item 27 is marked other the any Injury or other traumatic event, Inc. 2006. HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EICHELBERGER GLEN. BESSIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBRA COWGILL - DAUGHTER 236 N. SECOND ST. OAKLAND, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) OAKLAND CEMETERY 11/19/04 OAKLAND, MARYLAND 21. Signatur, of unera Serv 22. Name and Address of Facility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 to 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCLEROTIC CORONARY VASCULAR DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine signed by the attending physician and the detached for use as the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 Yes 2 ₹ No 1 🗆 Yes 2 🗆 No 4 or Attending Physicien: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death Check onl. one Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 T√Yes 2 □ No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No М 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H26154 NOVEMBER 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. DANIEL MILLER, D.O. 69 WOLF ACRES DRIVE OAKLAND, MD 21550 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** November 13 2004 13:20 PM Boyd Cleveland /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Cumberland Allegany Cumberland Nursing Center 8. Date of Birth (Month, Day, Year)
Oct. 7, 1933 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (Stete or Foreign Country) **Funeral** Months Days Hours 12 M 2 F 71 236-48-3128 Director Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Meryland Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exemples. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Cumberland 1⊠Yes 2□No MD. Allegany **Funeral Director** 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1 Baltimore St., Apt. 611 21502 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes ANO 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Railroad Brakeman 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Olin Cleveland Dorothy Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Gloria Cleveland/ wife 16506 South Conda Way, Rawlings, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 11/16/ 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Philos Cemetery Westernport, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 2004 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 111 Church St., Westernport, Maryland 21552 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician cardo vescular disense Immediate Cause (Final disease or condition resulting in death) /Medical 10 years Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physicism: The law requires thet the death certificete be executed use as the bunel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) After this certificate has been signed by the funerel director, page 2 should be deteched it Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No efter death.

Director: After this 27. Menner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) completely filled in by 4 ☐ Homicide within 24 hours 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated (Check only Examiner: Ori the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature end title of certifie Novamber 15, 2004 D36766 30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Vikramaditva Poonai 924 Seton Dr. Cumberland, MD.

**DHMH 16 Rev 6/95** 

State

Registrar

Dr. Vikramaditya

NOV 1 6 2004

31. Date filed (Month, Day, Year)

Poonai

32. Registrer's Signature

State Registrar filed (Month, Day, Year) **NOV 24** 2004

TORONE

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2. Registrer's Signature

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	1 - Stata Registrar Ce	artment of Health and Mental Hertificate of Death	Reg. No. 2004 37965
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last)  ALBERT BLANCHARD DEVINE  4a. Facility Name (If not institution, give street and number)	2. Date of I Month NOVEM.	Day Year
Funeral Director	515 PALMER LANE  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 181-34-5606 1 M 2 □ F 62 Yrs.  Usual Residence of Decedent	Months Days Hours Min. (Month, I	GARRETT  Sirth Day, Year)  15, 1942  GARRETT  9. Birthplace (State or Foreign PA) PA  PA
ith the Maryland or 28a-f show so rollited at	10a. State 10b. County 10c. City, Town or L  MD GARRETT OAKLAN  10e. Street and Number		10d. Inside City Limits 1 ☐ Yes 2 ☐ No  10g. Citizen of What Country?
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If Health and Mental Hygiene is the manual to a 28 or 28a-f show other treumatic event, the Marical Examinat must be notified at other treumatic event, the Marical Examinat must be notified at To Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2X Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ XYes 2 □ No 1964 — If Yes, Give 1966	Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☒ No Specify:	USA  14. Race - American Indian, Black, White, etc.  Specify: WHITE
Hygiene.  Hygiene.  Sther then "netural ant, the Medical E	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  1 2 College (1-4or 5+)  BUSIN	dent's Usual Occupation be kind of work done during most of working DO NOT use retired)  IESS OWNER	16b. Kind of Business/Industry  RADIO STATION
ind Mental Hy marked oth umatic even	17. Father's Name (First, Middle, Last)  JOSEPH JAMES DEVINE, SR.  19a. Informant's Name/Relationship (Type, Print)  19b. Maili	18. Mother's Name (First, Middle MARGARET  Ing Address (Street and Number or Rural Route Num.	KENNEDY
of Health ar	JEANNE DEVINE - WIFE 515  20a. Method of Disposition 1 🕅 Burial 2 Cremation 3 Removal from State	PALMER LANE OAKLAND, osition (Name of matory or other place)	MD 21550  20c. Location - City or Town, State
Department of Himportant: If ite any injury or of once.	21. Signature of Funeral Service Licensee 2.	IEMORIAL GARDS.11/22/04  2. Name and Address of Facility  DURST FUNERAL HOME - OAK	OAKLAND, MARYLAND
oding physician and less as the burial-transit aurignment and less as the burial-transit aurignment are aurignment and less are also also also also and less are also also also also also also also also	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 ary leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		arrest, Approximate Interval Between Onset and Death
d by the attending physical eached for use as the the the the the the the the the the		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
be q	Part II. Other significant conditions contributing to death but not resulting in the u		tobacco use contribute to the cause of death?  Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
or, page 2 should e Completed	25. Was case referred to medical	1 ☐ Yes	ppsy prior to completion of cause of death? 2 № No 1 ☐ Yes 2 ☐ No
fler this cer ineral direct on: To B	examiner?  1		
within 24 hours after death.  To the Funerel Director: After t completely filled in by the funere  Medical Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specity)	City or To	(Street and Number or Rural Route Number, wn, State)
thin 24 hours the Funer ompletely fill	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, deatt and manner stated.  Certifying Physician: To the best of my knowledge, deatt and manner stated.	vestigation, in my opinion, death occurred at the time,	date and place, and due to the cause(s)
within 24 hours after death. To the Funerel Director: After completely filled in by the fune Medical Certification	30. Name and address of person who completed cause of death (Item 23a) (Type,		29d. Date signed (Month, Day, Year) NOVEMBER 19, 2004
State Registrar	P. DANIEL MILLER, D.O. 6	9 WOLF ACRES DRIVE OAKI	AND, MD 21550

		•	1 - State Registrar	State of M	larylan		artmen rtificate					giene	004	3	3796	56
			1. Decedent's Name (First, Middle, La	st)					_		2. Date of Dea	ith			3. Time of D	eath
	Physici		Amy Elizabeth	Everett	_						Month No V	Day 18	Yea 200		300	AM
	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City,	Town, or	Location of	of Death	700	7 ~	County of De	-		-
н	Exami	٠.	13026 Mattley Dr	ive			Нае	erst	own			W	ashin	gtor	1	
	Funeral		5. Social Security Number 6. S		ge (In yrs. i	ast birthday)	If Under	1 Year	If Under		8. Date of Birth			Birthplac	e (State or F	Foreign
	Director		220-88-4109	☐M 252F	3	7 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Jan. 3,	1967	M	Country	land	
			Usual Residence of Decedent													
	show		10a. State 10b. County		10c. City	, Town or Lo	cation							10d.	. Inside City	
	Ma e-f.s	to	Maryland Washi	ngton	Ha	agerst	own								1 Tes 2	<b>№</b> No
	h th	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What	Country	?	
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	de at	Jer	11. Marital Status	12. Was Deceden		S. 13.	Was Deced	lent of Hi	spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)	1-	4. Race - Ar			
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93	ie", c	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	ZEU NO	Specify:			'	Specify: W	MITT	е	
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21	Page 1	ğ	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT us	e retired,	)		9					
2	er th	Son	12	4		Teac	her					Ec	ducati	on		
pu	al Hy loth	Be (	17. Father's Name (First, Middle, Last,						18. Mothe	er's Nam	e (First, Middle,	Maiden S	Sumame)			
<u>a</u>	Aents Aents rked tic e	To	Arthur H. Burgar	Jr.					Eli	zabe	th Hebb	Burg	gan			
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Σ	alth alth 27 is		Patrick J. Everet	t/Husband		13026	Matt	:ley	Driv	e, H	agersto	wn, l	Md. 21	742		
ē,	s 1 a f He itam othe		20a. Method of Disposition		1 0	lace of Dispo	sition (Nan	ne of	9)		Date	20c. Loc	ation - City	or Town	, State	
9	Page ent o ht: #		12 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif		•	t Have	-	•	1	1/20	0/2004	Насе	rstow	n. N	(arvla	nd
Baltimore,	permit. Pages 1 and 2: Department of Health ar Important; If item 27 is any injury or other trau	1	21. Signature of Fuperal Service Lices		Rec						st Haven					
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			23a, Pert1. Enter the disease, or com	plications that cause	d the death				-				1000W	17	pproximate	
н			shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.	4		,	,		,			ln!	terval Betwe nset and De	
4	Physician /Medical		disease or condition resulting in death)	a	(0	100	lar	100						1	4 mor	·h
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		Ļ	Sequentially list conditions,	b. Due to (or as		ionas afti								J		
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	and and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or a:	s a consent	ence of):								-		
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit	Ë		200 10 (0. 0.	. u 00.1100q1	30.100 01).										
87	cate be ex physician the buria	dicai		d										-		
9	eath certific attanding p	Me	IF FEMALE:	00- 16		and the same										
Вох	ath c	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal	death 3	Ectopic pre					23	3d. Date of d Month	lelivery Da	v Yea	ar
	he a	sic	1 ☐ Yes 2 ☐ No	4☐Pregnant a 9☐Unknown	at time of de	eath 5□	Other (sp	ecify)							,, , , ,	••
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	uires that the de signed by the a Id ba detached f	by Physician/Me	Part II. Other significant conditions of	ontributing to death	but not resu	alting in the u	nderlying ca	ause give	n in Part I.				/		ause of dea	
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Vital	ician: Th certificate ector, pag	0	25. Was case referred to medical						26 Place	of Deat	(Check only or					
5		ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpat	ient 2	ER/Outpatier	it 3 DO	A Othe			me 5 Reside		□Other (Sr	necify)		- 17
of	Phys rrthis aral di	Ξ.	27. Manner of Death	28a. Date of Inj (Month, Da		28b. Time of		8c. Injury Work	at		28d. Describe he			ouny)		
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Ö	after Dire	erti	4  Homicide	building, e	itc." (Specify	)	,				City or Town	n, State)				
	spita ours narel filled	2	29a. Certifier 1 Certifying Ph	ysicien: To the bes	t of my know	wledge, death	Occurred :	at the tim	e, date an	d place	and due to the c	ausa(e) a	nd manner :	as state	d.	
	To the Hospital or Attanding Phy within 24 hours after death. To tha Funarel Diractor: Aftar this completely filled in by the funaral or	Medical	(Check only 2 Medical Exer	niner: On the basis	of examinat	ion and/or in	vestigation,	in my op	inion, dea	th occurr	ed at the time, d	ate and p	lace, and di	ue to the	e cause(s)	
	o the	Me	29b. Signature and title of certifier				29c	. License	number		2	9d. Date	signed (Moi	nth, Day	v. Year)	
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•	/		" Michael /	necon	mul_	· rn c		1	111	- 6	(	- /	1.18		7	
	1-6		30. Name and address of person who	completed cause of	death (Item			,	,,		12		1.1e		1000	1710
2	ζ,		31. Date filed (Month Day Melis)	Ormack 32 Phos	rar's Signa		ne di	CH	lan	nfu	J 172	Jer	1/62.	~ Y	10) 2	119
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** LUCILE EATON FRANCIS 11/12/2004 1407 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14 Watergreen Lane Ocean Pines Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Days 1 □ M 2 XF 82 Yrs. Director 07/17/1922 042-16-7466 Cť. Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b County Item 27 is marked other then 'natural', or items 23a or 28a-1 show other traumatic event, the Modical Examiner must be notified at 10d. Inside City Limits 1 XYes 2 □ No Director VA Fairfax Springfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7446 Spring Village Drive 22150 **USA** by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within.
Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other then any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) Secretary 12 Commercial Photography 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Harold Eaton Mabel Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill Kritzer (daughter) 10328 Sager Ave. #104 Fairfax, VA 22030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Cape Henlopen Crem, 11/15/2004 Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 2/a. Part1. Enter the disease, or complications that cause shock, or heal-railure. List only one cause on each 108 William Street Berlin, MD 21811 Or ot enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physicien Box 68760 Physician/Medicai the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death Month Day Year 5 Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1☐ Yes 24 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 1 Yes 2 No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation **Diractor**: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) within 2 To the Corbert 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY, MD. 21801 ROBERT L. CLINTON, M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 5 2004 LABOR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 004 37968 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 9, 2004 Mary Fahy 10:45 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

7. Age (In vrs. last birthday)

Yrs.

10c. City, Town or Location

96

Silver Spring

Days

If Under 1 Year If Under 24 Hrs.

Montgomery

9. Birthplace (State or Foreign

10d. Inside City Limits

Ireland

8. Date of Birth (Month, Day, Year)

July 9, 1908

**Physician** /Medical Examiner

1713 Colesburg St.

10b. County

1 ☐ M 2 🖫 F

5. Social Security Number

124-12-8615

10a. State

Usual Residence of Decedent

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "naturat," or Itams 23a or 28a-f show any jury or other traumatic event, Ira Medical Ever in write at the multised at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

tor	Maryland Montgomery	Silv	er Spring				1 Yes 2 □ No	
Funeral Director	10e. Street and Number 1713 Colesburg St.		10f. Zip Code 2090	6	10g.	Citizen of What C	Country?	
by Funer	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent E Armed Forces? 1 Yes 2 N 1 Yes 2 N 1 Yes 2 N 1 Yes or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (S In, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh Specify:		
Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5	(4)	Decedent's Usual Occup:     (Give kind of work done of life. DO NOT use retired.)	during most of wo ()	rking 16b	16b. Kind of Business/Industry		
Con	Elementary/Secondary (0-12) College (1-4or 5	M	edical Assis	tant		Health	care	
To Be	17. Father's Name (First, Middle, Last) Eugene Egan			18 Mother's Na Mary Ho	me (First, Middle, Maid are	den Sumame)		
	19a. Informant's Name/Relationship (Type, Print)	191	b. Mailing Address (Street a	and Number or R	ural Route Number, Ci	ty or Town, State,	Zip Code)	
	Barbara Brown- Daughter	g, MD 20	906					
	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	Location - City onelawn, N	New York					
	21. Signature Funeral Service Licensee	i Funera Ver Spri	I Home ng, MD 20904					
	23a. Part1. Inter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition Congo		not enter the mode of dying Heart Failur	or respiratory arrest,		Approximate Interval Between Onset and Death 1 Week		
	resulting in death)	a consequence						
nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	rioscle a consequence	erotic Heart of):	Disease			7 Yrs.	
ilcal Exa	that initiated events consequence of):  Due to (or as a consequence of):  d							
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of the pregnant at 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2 Fetal death	n 3 ☐Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delivery Month Day		
ed by Pr	Part II. Other significant conditions contributing to death bu Acute Bronchitis	it not resulting i	in the underlying cause give	en in Part I.		tobacco use contribute to the cause of death?  Yes 2   No 3  Probably 4 □Unknown		
Complet					24a. Was an autopsy performed 1 Yes 24	prior to death?	utopsy findings available completion of cause of	
Be	25. Was case referred to medical examiner?				th (Check only one)			
2			utpatient 3 DOA Cthe	4 Nursing H	ome 5 Residence	6 ☐Other (Spe	ocify)	
catlon	27. Manner of Death  1		Time of 28c. Injury Work  M 1 \( \triangle \) Y	at ? ∕es 2 □ No	28d. Describe how in	jury occurred		
Certifi	3 Suicide 6 Could not be determined 28e. Place of Injurbuilding, etc.	ry - At home, fa . <i>(Specify)</i>	arm, street, factory, office		28f. Location (Street City or Town, Sta	and Number or R ate)	ural Route Number.	
Medical Certification:	29a. Certifier (Check only one)  1 Certifying Physician: To the best of and manner state	examination an	e, death occurred at the tim nd/or investigation, in my op	e, date and place inion, death occu	, and due to the cause rred at the time, date a	(s) and manner as and place, and due	s stated. to the cause(s)	
Σ	29b. Signature and title of certifier		29c. License	number	29d. [	Date signed (Mont	h, Day, Year)	
	Leone Mx Jonasla	20k	D12	121	Nov	ember 10	, 2004	

State

Registrar

George Sengstack, M.D. 3929 Ferrara Dr. Wheaton, MD 20906

32. Registrar's Signature

30. Name and address of person who complet a cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV

15

2004

	-07350	ei	th Grant Pleas	se Type or Pr				•	_	ile.
Κυ			1 - For State Registrar	State of h	Maryland / De C	epartment of Certificate of		Mental Hy	/glen2 0 0	4 37969
	Physic	an	1. Decedent's Name (First, Middle	o, Last)	-			2. Date of D		3. Time of Death
9	/Medi		William Keit					Novemb		08:50AM
	Examir	ner	4a. Facility Name (If not institution,	, give street and numbe	or)	4b. City, Town	, or Location of Deat	h	4c. County of	f Death
	Funeral Director		12057 Kemps Mi 5. Social Security Number 236-90-6553		Age (In yrs. last birtho	(ay) If Under 1 Year Months Day			rth ay, Year)	gton County 9. Birthplace (State or Foreign Country) West Virgini
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Logation			, , , , , , , , , , , , , , , , , , , ,	
	Aaryle I sho	ō			Too. Ony, Town o					10d. Inside City Limits 1 ☐ Yes ২/২/১۷০
	ith the Ma or 28a-f	Director	West Virginia Be	erkeley		Falling W 10f. Zip Code			10g. Citizen of Wh	
	11 with	a D	54 Dove Lane				25419		US	ΣΔ
	ems .	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13. Was Decedent of	f Hispanic Origin? (Suban, Mexican, Puert	pecify Yes or No	o- 14. Race	- American Indian,
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23e or 28a-f show or other treumatic event, the Medical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4XX ivorced		Q No	1 Yes 2 N		o moan, etc.)	Specify:	White, etc.
5	72 h	etec	15. Decedent' (Specify only highest	's Education t grade completed)	(6	ecedent's Usual Occi	e during most of wor	rkina	16b. Kind of Busi	
2121	within iene. then "	Completed	Elementary/Secondary (0-12)	College (1-4o	lis	e. DO NOT use retir	red)			
	filed Hygie other	Be C	17. Father's Name (First, Middle, L	Last)		Owner	18. Mother's Nar	ne (First, Middle	, Maiden Sumame	struction
Maryland	should be nd Mental marked o	To B	William Neill	Grant			Frances	Marie	ne Table	r
lar	and 2 sho lealth and m 27 Is mu her treums		19a. Informant's Name/Relationsh	nip (Type, Print)	19b. M	ailing Address (Stree	et and Number or Ru	<i>iral R</i> ou <i>te N</i> um <i>b</i>	er, City or Town, St	rate, Zip Code) 25419
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other to <u>once</u> .		1 ABurial 2 Cremation 4 Donation 5 Other (Sp  21. Signal are of Funeral S	pecity)	Pleasant	View Mem. Ga 22. Name and Add USBOTNE F 125 S. Cor	ardens Nov. Funeral Honococheagu	19,2004 ome, P.A ne St. W	Martinsb illiamspo	West Virginia ity or Town, State urg. West Virgin 21795 ort, Mary land
	Physician /Medical		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	_aM	ed the death. Do not line.  UTTIPU as a consequence of):	enter the mode of dy	ying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
ı	Examiner .		Cognostially list conditions	h						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	s a consequence of):					
68760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or a	s a consequence of):					
O. Box	death certii e attending id for use a	Physiclan/Medlcal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	су		23d. Date of Month	,
rds, P	w requires that the been signed by th should be detache	by	Part II. Dther significant condition	ns contributing to death	but not resulting in the	underlying cause g	iven in Part I.	23e. Did t	10	ute to the cause of death?  Probably 4 □Unknown
Il Record	The law ate has b page 2 si	Completed						24a. Was autop perfo Yes		re autopsy findings available or to completion of cause of th? Mes 2 □ No
Vital	Physicien: T this certificat ral director, ps	Be (	25. Was case referred to medical examiner?	11			26. Place of Deat			
of \	Physi this c	To.	1 XYes 2 No		ient 2 ER/Outpar	IBIT 3 DOA				(Specify) At scene
Division (	ing After une	ertification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	ation 1115	by 300	A M 10	Yes 2 No	28d. Describe	now injury occurred  185ECT U	AS SYUT
Divi	of or Attend after death Director: /	ertiff	3 Suicide 6 Could no 4 Homicide determin	286. Place of it	njury - At home, farm, etc. (Specify)	street, factory, office		28f. Location (S City or Tox	orn, State) 1705	TRUTAL ROUTE Number, 7 KEMPS MILL

To the Hospitel or Attending Physicien: The law requii within 24 hours after death.

To the Funerel Director: After this certificate has been s completely filled in by the funeral director, page 2 should Be Completed Medical Certification: To

29a. Certifier

SUBJECT WAS SHUT 28f. Location (Street and Number or Rural Route Number, City or Town, State) 17057 KEMPS MILL (LCHD, WILLIAMSPORT; M)

1 Certifying Physician: To the best of my mowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of c

29c. License number OCME

29d. Date signed (Month, Day, Year) November 16, 2004

30. Name and addre

e of death (Item 23a) (Type, Print) 31. Date filed (Mor. 2004

32. Rigistrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State

			1 - For State Registrar	State of Ma	aryland		irtment of tificate of		ınd Me		ene 0 0	14	37970
	Physicia /Medic		Decedent's Name (First, Middle, Last)     JOHN BROOKE	GUNNIN	G, JF	₹.			2.	Date of Death Month	Day	Year 04	3. Time of Death 4:00 P M
	Examin		4a. Facility Name (If not institution, give s Atlantic General h				4b. City, Town, Berlin	or Location of	f Death		4c. County		
0	Funeral Director		5. Social Security Number 6. Sex	7. Age	(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days		Min.	Date of Birth (Month, Day, Une 29	Year)	9. Birthpl Coun	lace (State or Foreign try) <b>yland</b>
0 1600	yland now		Usual Residence of Decedent  10a. State 10b. County		10c. City, 1	Town or Loc	cation			25,	15251		0d. Inside City Limits
	ith the Marylan or 28a-f show e notitled at	rector	Maryland Worcester  10e. Street and Number	•	Berli	n	10f. Zip Code			10	g. Citizen of W	/hat Coun	1 ☐ Yes 2 <b>X</b> No try?
11/12/2004	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heatth and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be rectified at	Funeral Director	170 Nottingham La  11. Marital Status  1 □ Never Married ※ Marned	2. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates.			21811 Vas Decedent of Yes, specify Cul		gin? (Specif , Puerto Ric	y Yes or No- can, etc.)	14. Race Blace	- America	etc.
15-0036	n 72 hours • natural',	eted by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ (Specify only highest grade	ation		16a. Deced	ent's Usual Occu	ipation during most	of working	1	6b. Kind of Bu	Whit	
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yland	should be find Mental Hamked of	To Be	John Brooke Gunn					Mar	ry Eli	zabeth	Fick		
Jehn 2-1914 Maryl	os 1 and 2 shoot Health and item 27 Is m		19a. Informant's Name/Relationship (Typ. Margaret Elizabeth				g Address (Stree Nottingh					State, Zip	Code)
Gunning, 214-2 Baltimore,	Pages 1 and of He		20a. Method of Disposition  1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	cem	etery, crem	sition (Name of natory or other pla		Date		rankfo		
Gun 2 Baltii	permit. Pages Department of I Important: If ite any Injury or of		21. Signal of Fundal Service License	e Carlo Ca	Cupt	22.	Name and Addr	ess of Facility		108	B Willian	m St.	
8760,	Physician /Medical Examiner on the printing the printing the printing the printing the printing the printing the printing the printing the printing that the printing the printing that the prin	sal Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	e cause of each lin	e.  MO  a consequent  consequent	nce of):						nerl	Approximate Interval Between Onset and Death  Sury S  10 Gan
P.O. Box 68	Attending Physician: The law requires that the death certificate er death.  ector: After this certificate has been signed by the attending physt by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 Fetal de	ath 3 🗆	Ectopic pregnand Other (specify) _	ру			23d. Date Mon		TY Day Year
ds, P	v requires that been signed b should be deta	by	Part II. Other significant conditions con	ributing to death bu	it not resultir	ng in the un	derlying cause gr	ven in Part I.					e cause of death?
Division of Vital Records,	ysician: The law requiscentificate has been director, page 2 should	Completed								24a. Was an autopsy perform 1 Yes 2	ed2 pr	ere autoprior to come eath?	sy findings available apletion of cause of
Vita	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:	OFD	10. 1	on no. Ot	han		heck only one			
on of	ding Phys h. After this funeral dia	tion: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injun (Month, Day		Outpatient  Bb. Time of Injury	28c. Inju	4 🗀 NUI!	28d		rice 6 □Othe vinjury occurre		
Divisi	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home . (Specify)	a, farm, stre				Location (Stre City or Town,	eet and Numbe State)	r or Rural	Route Number,
	ne Hospi n 24 hou ne Funer bletely fill	ledicai	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best o er: On the basis of and manner stat	examination	dge, death and/or inv	occurred at the t estigation, in my	ime, date and opinion, death	place, and h occurred a	due to the cau at the time, dat	use(s) and man e and place, ar	ner as sta nd due to	ited. the cause(s)
	To the within to the comp	Me	29b. Signature and title of certifier	LELL	Ly5K	۔۔ می لیے	29c. Licen	se number 42 83		296	d. Date signed	(Month, D	ey, Year)
C.H	.6t1		30. Name and address of person who con	npleted cause of de	9733	Ba) (Type, F	MWZ4	Dri	rl	Ben	lu,	200	1
	Sta		31. Date filed (Month, Pay Year) 6 20	32 Registra	r's Signatur	So	artis						

			1 - State of Maryla		artment of I		Re	g. No. U U 4	37971
	Physic		1. Decedent's Name (First, Middle, Last)  Nelda Louise Cole Harris				2. Date of Death Month	Day Ye	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give street and number) PUNINSYUR REGIONAL MEDICAL	CONFU	5/1	or Location of Death	November		Death ·
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In y. 235-40-6014 1 ☐ M 2 ☒ F 80	rrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8-15-19	Year) 9. 24	Birthplace (State or Foreign Country) W • VA •
	e Maryland Ba-f show tiffed at	Director	10a. State 10b. County 10c.  Md. Wicomico	City, Town or Lo	cation				10d. Inside City Limits 1 Tyes 2/1 No
	h with th	al Dire	10e. Street and Number 8941 Lynch Drive		10f. Zip Code 218	375	10	g. Citizen of Wha USA	t Country?
920	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortent: if item 27 is marked other then "neturel", or iteme 23a or 28a-f show injury or other treumatic event, its Marical Examinar must be notified at injury or other treumatic event, its Marical Examinar must be notified at #8.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Yes 2 ZNo If Yes, Give Year or Dates:	1	Was Decedent of I- f Yes, specify Cub 1 ☐ Yes 2 → No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, V	American Indian, White, etc. White
21215-0036	d within 72 ho jiene. r then "netui r to Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+) 8	(Give	DO NOT use retire	during most of work	ing	6b. Kind of Busing	ess/Industry
Maryland 2	should be filed nd Mental Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Everett Eugene Cole			18. Mother's Name	e (First, Middle, M		
	1 and 2 sho Health and Iem 27 Is mu		19a. Informant's Name/Relationship (Type, Print)  Ira O. Harris, Jr. Son	420	Dogwood	and Number or Rura Dr. Salis	bury, Md	. 21801	
Baltimore,	Pages 1 nent of H ant: If ite ury or ot		1 D Dulia 2 O Clariation 3 O Mainoval noin State		sition (Name of natory or other plac Chapel Ce	1		Oc. Location - City	
Balti	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee	Sł	Name and Addre			100/0	
i	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	eath. Do not ente	er the mode of dyir	ng, such as cardiac o	or respiratory arres	19940 st,	Approximate Interval Between Onset and Death
	death certificate be executed XX e attending physician and deruse as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a cons or conscience of the conscience o	equence of):					
9	death certifi e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
rds, P	The law requires that the ite has been signed by those 2 should be detache	by	Part II. Other significant conditions contributing to death but not r	esulting in the un	nderlying cause giv	en in Part I.		_	e to the cause of death?  Probably 4 Dinknown
Vital Records,		Completed	V				24a. Was an autopsy performe 1 🗆 Yes 2	prior	
O	S	ation: To Be	25. Was case referred to medical examiner?    Yes   2 No	ER/Outpatient 28b. Time of Injury	28c. Injur Wor	4   Nursing Hor	me 5 Residen Residen Residen	ce 6 Other (S	Specify)
DIVISION	tel or Atters after detented Directored in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spe		eet, factory, office	-	28f. Location (Stre City or Town,		r Rural Route Number,
	To the Hospitel or Attending Phywithin 24 hours after death. To the Funerel Director: After this completely tilled in by the funeral	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my k 2 Medical Exeminer: On the basis of examinand manner stated.	nowledge, death nation and/or inv	estigation, in my o	pinion, death occurre	ed at the time, date	e and place, and o	due to the cause(s)
	V vitl	~	29b. Signature and title of certifier		29c. Licens	3678 3	290	d. Date signed (Mo	onth, Day, Year)
/	PAP		30. Name and address of person who completed cause of death (It	hertor	Print)	PRU	C SA	ISBURY	y, mo.
	sta Registr	-2	NOV 1 2 2004 32. Registrar's Sig	nature	Spork	N			

		·	1 - For State Registrar	State of Maryla		artment of H			giene Reg. No.2	004	37972
	Physici		Decedent's Name (First, Middle, Last     WILLTAM EAST	HURLEY				2. Date of De. Month November	Day	Year	3. Time of Death # //
	/Medio		4a. Facility Name (If not institution, give	a street and number) Apt. D-6			ke City	th	4c. Cour	nty of Death	er
	Funeral Director		5. Social Security Number 6. S 215-20-1457 Usual Residence of Decedent	ex 7. Age (In yrs	. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		v Yearl	9. Birth Cou 24 Ma	nplace (State or Foreign untry) ryland
	ne Maryland 8a-f show Aiffied at	ector	10a. State 10b. County  MD Worceste		ity, Town or Lo	City					10d. Inside City Limits 1 XYes 2 ☐ No
	3e or 2	Dire	10e. Street and Number  1210 Market St.,	Ant D-6		10f. Zip Code 21851			10g. Citizen o	of What Cou JSA	untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "netural", or Items 23e or 28a-f show any injury or other treumatic event, I'm Medical Examinations in colling an once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? ( In, Mexican, Puel Specify:	Specify Yes or No rto Rican, etc.)	14. R		
Maryland 21215-0036	d within 72 ho giene. er than "netui . I've Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12		(Give	lent's Usual Occupa kind of work done o OO NOT use retired	during most of wo	orking	16b. Kind of Insura		ndustry
land	uld be file fental Hy rked othe tic event,	To Be (	17. Father's Name (First, Middle, Last) Olden W. Hurley					me <i>(First, Middl</i> e, Elizabeth		ame)	
Aary	12 shou and M Is mai reumat	(F 2	19a. Informant's Name/Relationship (			ig Address (Street a					
Baltimore, I	Pages 1 and ent of Health nt: If item 21 ry or other 1	8	William Allen Hurley  20a. Method of Disposition  1 Magurial 2 Cremation 3 Community  4 Donation 5 Other (Specific	20b.	Place of Dispo cemetery, cren	Klej Grai sition (Name of natory or other plac Presbyteria	e) 11/1	Date 17/2004	20c. Location	n - City or T	
Balti	permit. I Departm Importer any injur		21. Signature of Funeral Service Licer		HC 22	Name and Address olloway Me 3 Linden	ss of Facility elson Fu	neral Ho	me, P.	Α.	
8760,	Physician and build-transit sthe build-transit	dicai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.)	quence of):	er the mode of dying	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
P.O. Box 6	ne death certif the attending thed for use a:	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	aldeath 3 [	Ectopic pregnancy Other (specify)				Date of deliv Month	very Day Year
Ś	quires that the signed by and be detacted		Part II. Other significant conditions o	ontributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.		bacco use co		the cause of death?
Division of Vital Record	The law require ate has been signage 2 should t	Completed						24a. Was autop perfor 1 Yes	sy med?	prior to co death?	opsy findings available ompletion of cause of
Vita	Physicien: this certificatal director, I	Be	25. Was case referred to medical examiner?  154 Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐	TER/Outpation	Othe	200	ath (Check only or			76.1
ion of	To the Hospital or Attending Physicien: The la within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe h			<u>ny)</u>
Divis	tal or Atte s after de el Directo ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Num n, State)	nber or Run	al Route Number,
	To the Hospital or A within 24 hours after To the Funerel Direct Completely filled in by	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☑ Medical Exam	ysician: To the best of my kn niner: On the basis of examin- and manner stated.	owledge, death ation and/or inv	occurred at the timestigation, in my op	ne, date and place pinion, death occ	e, and due to the durred at the time, o	ause(s) and n late and place	nanner as s and due t	stated. to the cause(s)
)		M	29b. Signature and title of certifier	Hohunth,	m. d.	29c. License	06241	ľ	Nov.		Day, Year)
<b>3</b> -	C.H		30. Name and address of person who			Print) D. 20	3 SNOW	57, 3	SNOW H	14,1	ND. 2/863
	Sta Registr	_	31. Date filed (Month, Day, Year)  NOV 1 5 2	32. Augistrar's Sign	ature	north					

State of Maryland / Department of Health and Mental Hygien 37973 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death S Physician Julia Margaret Hayes November 21,2004 9:25 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Homewood Williamsport Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 31, 1920 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. 84 Director 220-16-0372 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits irel", or items 23e or 28a-f sh Examiner must be notified Md. Washington Smithsburg Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11741 Mapleville Rd. P.O. Box 35 21783 Funeral U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3X Widowed 4 □ Divorced Specify: White neturel Completed other traumatic evant, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 2 should be filed very and Mantal Hygie is markad other t Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lancelot Jacques Jr. Margaret Nicodemus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parmit. Pages 1 and 2 s Department of Health an Important; if item 27 is: any injury or other trau Nancy A. Roisum (Daughter) 7204 Homestead Place Springfield, Va. 22151 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Nov. 22. Smithsburg Crematory 2004 \* 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 MO1414 Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MIKE /Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions п any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami g physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical esn. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2.XNo 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has Ne 10500000 1 ☐ Yes 2 No Was case referred to medical examiner? uneral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient ٩ 1 ☐ Yes 2 No Other: 2 ER/Outpatient 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c Injury at Work? After Certification 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel E to critifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifies 29c. License number ss p person who completed cause of death (Item 23a) (Type, Print) Mortano 32. Registrar's Signature Registrar

			1 - State of Maryland / Dep Registrar  State of Maryland / Dep	artment of Health and Mertificate of Death	lental Hygi	ene2001	37974
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Patricia Joan Hussey		2. Date of Death Month	3	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number) 1926 Merrimac Dr.	4b. City, Town, or Location of Death Adelphi		4c. County of Dec	ath
	Funeral Director		5. Social Security Number  578-56-3517  Usual Residence of Decedent  6. Sex 1 M 2 F 61  Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, June 25,	9. Bi 1943 Was	orthplace (State or Foreign Country) hington, DC
	e Maryland 8a-f show Ililiad at	ctor	10a. State 10b. County 10c. City, Town or L Maryland Prince George's Adelphi	ocation			10d. Inside City Limits 1 X Yes 2 □ No
	ath with th s 23a or 28 nat be no	ral Directo	10e. Street and Number 1926 Merrimac Dr.	10f. Zip Code 20783		g. Citizen of What C	
036	urs after de el', or Items Examiner n	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 2 Married  1 Never Married 2 M	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	erican Indian, ite, etc. White
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23a or 28a-1 show any injury or other traumatic event, the Modical Exercipent matter matter once.	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)  ol Bus Driver	na	6b. Kind of Business rince Geo Schoo	rge's County
yland ;	ould be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) Leo Frene	18. Mother's Name Cora Lee		aiden Sumame)	15
e, Mary	and 2 sho lealth and i m 27 is me		Paul Hussey- Husband 1926	ng Address (Street and Number or Aura Merrimac Dr. Adel	phi, MD		Zip Code)
Baltimore,	it. Pages 1 Intment of H Internate If its Injury or ot		*4 Donation 5 Other (Specify) George W.	ashington Cem. 11/	6/04 A	delphi, M	D
Ba	Deparation of the property of		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	2. Name and Address of Facility Hin 1800 New Hampshire ter the mode of dving, such as cardiac o	Ave. Si	lver Spri	
1	rnysician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a				Interval Between Onset and Death 5 Yrs.
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8760,	cate be executed physician and the burial-transit	dical Exa	resulting in death) Last  Due to (or as a consequence of):  d.				
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rds, P	w requires that the de been signed by the s should be detached t	by	Part II. Other significant conditions contributing to death but not resulting in the u  Coronary Artery Disease	nderlying cause given in Part I.			o the cause of death?
al Records,	The law ate has b page 2 sl	Completed			24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of 2 No
on of Vital	ding Phys .r After this funeral dir	tion: To Be	25. Was case referred to medical examiner?  1   Yes   2   No			ce 6 Other (Spe	cify)
Division	lel or Attendi s after death. el Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		8f. Location (Stree City or Town,	et and Number or Ru State)	ural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deatt 2 Medical Examiner: On the basis of examination and/or in and manner stated.	estigation, in my opinion, death occurre	d at the time, date	and place, and due	to the cause(s)
į	5 with Co	~	29b. Signature and title of Certifier	29c. License number D32417		Date signed (Monti	**
				Print) re. Wheaton, MD 209	002		
	Sta Registr	-	31. Date filed (Month, Day, Year) NOV 15 2004	Sparks			

			1 - For State Registrar	State of Mai	-	epartme Certifica						)4	3797	5
	Physicia	an	1. Decedent's Name (First, Middle, Last						Mont	of Death	Day .	Year Year	3. Time of Death	
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	Examin	er	4a. Facility Name (If not institution, give National Lutheran				Rockv	Location o	or Death		4c. County of Mont		rv	
	Funeral		5. Social Security Number 6. Se		(In yrs. last birth	day) If Und	er 1 Year	If Under	24 Hrs. 8. Date	of Birth		9. Birthpl	ace (State or Foreig	n
п	Director		200 12 110	]M 2]⊠F	94 Y	rs. Month	Days	Hours	Min. Aug.	h, Day, Ye 6 I	910 W	lest	Virginia	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10	Od. Inside City Limits	s
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	n the	lrec	10e. Street and Number			10f. 2	ip Code		0000	10g.	Citizen of Wh	nat Coun	ry?	_
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			edent of H ecify Cuba 2'\(\sqrt{N}\)	ispanic Ori in, Mexicar Specify:	gin? (Specify Yes n, Puerto Rican, etc	or No- c.)	14. Race Black, Specify:	White,	an Indian, otc. Nite	
Baltimore, Maryland 21215-0036	hin 72 ho a. "natur Madical I	Completed	15. Decedent's Edd (Specify only highest grad	cation le completed) College (1-4or 5+)	- (	Decedent's Us Give kind of v life. DO NOT Memake	vork done d use retired	ation during mos ()	t of working	16b	. Kind of Bus Own Ho		ustry	
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yland	should be fi nd Mental H marked otl imatic ever	To Be	17. Father's Name (First, Middle, Last) George Frank	McDonald					er's Name <i>(First, M</i> ulia Ma	sters				
Man	and 2 sho Balth and n 27 Is m		19a. Informant's Name/Relationship (T) Harry L. McDonald						er or Rural Route A d, Layton				<sup>Code)</sup> 0882	
ore,	es 1 a of He of He if item ig othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	1	, crematory of	other plac	· 1	Date	1	. Location - C	•		- 10
Ĕ	Pages tment of I tant: If its		* 4 ☐ Donation 5 ☐ Other (Specify)		Gate o				11/15/04	_		Sprin	ng, Md.	
Bai	permit. Page Department Important: II any injury or		21. Signature of Funeral Service Licens  Nicriel W	Barke	V				y ber Fune 038, Layt			1d. 2	20882	
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9	g physi as the t	edica	•	d	or all	00110	->-	len	40-3/1			1	( ears	
.O. Box	The law requires that the death certific ite has been signed by the attending p rage 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 1√06 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at til 9 Unknown	Fetal death	3 □Ectopic 5 □ Other (				_	23d. Date Monti		y Day Year	
ds, P.	uires that n signed b	ρ	Part II. Other significant conditions co	ntributing to death out	not resulting in t	hynderlyin	cause give	en in Part I.		Did tobaco			e cause of death? ably 4 □Unknown	1
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n of \	Attending Physicien: r death. sctor: After this certifici by the funeral director.	on: To	1 Yes 2 No	1 Inpatient 28a. Date of Injury (Month, Day)	28b. Ti		28c. Injun	4 - NU	irsing Home 5 28d. Desc		6 Other		)	-
Division of Vital Records,	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury	y - At home, farr	M n, street, facto		Yes 2□	28f. Locat	ion (Street or Town, St		or Rural	Route Number,	
	oitel or A													
	To the Hospitel or within 24 hours afte To the Funeral Dirk completely filled in I	edicai	29a. Certifier 1 Descritiying Phy (Check only 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination and	death occurre or investigation	d at the tin	ne, date an pinion, dea	id place, and due to th occurred at the	the cause ime, date	e(s) and manr and place, an	ner as sta d due to	ited. the cause(s)	
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	V		30. Name and address of person who c				ivo	Rocky	ille, Md	2	0850		7	
	Sta	to	Charles W. Kares  31. Date filed (Month, Day, Year)	1, M.D. 32. Registrar		N.	,		iiic, riu				<u> </u>	
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State of Maryland / Department of Health and Mental Hygien 0 0 37976 Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month 13:10 PM Year Physician Pearl Savilla Hollada 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Comberland

If Under 1 Year | If Under 24 Hrs. Allegan acred Heart pita 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 M 2 XF 216-38-1910 Yrs. 86 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State "naturel", or Items 23e or 28e-f show polical Examiner must be notified at 1 ☐ Yes 2 TX No Garrett Frostburg Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21532 USA 16386 National Pike Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: white If Yes, Give Year or Dates: Specify: δ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) " neut College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wind Department of Health and Mental Hygien. Importent: If item 27 is marked other the any injury or other traumatic event Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jennie Thomas George Wilt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18123 Mt. Savage Rd., N.W., Frostburg, MD 21532 Angela L. Garlitz/niece Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Ann's Cemetery, Nov. 19,2004 Avilton, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A., PO Box 275 21. Signature of Funeral Service Licensee eumai 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 179 Miller St., Grantsville, MD Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year be detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknows 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 1 Yes 2₽ No 1 Yes 4RTE or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient Certification; To 2 ER/Outpatient 3 DOA this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending within 24 hours after deam.

To the Funerel Director: Aft 2 🗌 No 1 Yes 2 ☐ Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mberland Shiv KHANNA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 18 2004 Registrar

			1 - For State of Maryland Registrar	/ Department of Health and Men Certificate of Death	Reg. No. UU4 3/9//
	Physici /Medi Examir	cal	1. Decedent's Name (First_Middle, Last)  LVL N C  4a. Facility Name (If not institution, give street and number)	Hottman	Date of Death Month Day Year  Twentber 18, 2004  4c. County of Death
1	Funeral Director	ier	Oak Crest Village  5. Social Security Number  6. Sex  1 M 2 F  97	t birthday) If Under 1 Year   If Under 24 Hrs. 8. 7	Date of Birth (Month, Day, Year)  Uly 30, 1907  Baltimore  9. Birthplace (State or Foreign Country)  Maryland
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28e-1 show other treumatic event, I'm Medical Everther must be rediffed at	To Be Completed by Funeral Director	Maryland Baltimore Pa  10e. Street and Number  8832 Walther Boulevard  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  Thomas Henry Draper, III	Frances	Specify: Caucasian  16b. Kind of Business/Industry  Board of Education  irst, Middle. Maiden Sumame)  (unknown)
Baltimore, Mar	permit. Pages 1 and 2 sho Department of Health and Importent: If Item 27 Is ma any injury or other treums		Personal  Genevieve J. Johnson, Representative  20a. Method of Disposition  15 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licenses	con Cemetery 11/23/2 22. Name and Address of Facility  Montro Physics 11/20 D	el Air, Maryland 21014 20c. Location - City or Town, State 2004 Denton, Maryland
8760,	Physician pe executed for an included physician and physician and properties as the purial-transit	sai Examiner	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhitated events resulting in death) Last  C. Due to (or as a consequence of the con	noe of):	
Box 6	certific nding p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ② Mo 9 □ Unknown 23c. If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
Records, P.O.	requir been s should	by	Part II. Dther significant conditions contributing to death but not resulting		23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown  24a. Was an 24b. Were autopsy findings available
Vital Rec	The ate h page	Be Completed	25. Was case referred to medical examiner?	26. Place of Death (Ch	autopsy performed?  1 Yes 2 No
Division of \	ting Phys	Certification: To		3b. Time of Injury at Work?  M 1 □ Yes 2 □ No  a, farm, street, factory, office 28f. I	5 Residence 6 Other (Specify)  Describe how injury occurred  Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospitel or Attene within 24 hours effer death To the Funerel Director: completely filled in by the	Medical C	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	adge, death occurred at the time, date and place, and on and/or investigation, in my opinion, death occurred at	at the time, date and place, and due to the cause(s)
	To T To I	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Sta	ate -	30 Name and address of person who completed cause of death (Item 2:	then Blod, Parku	Me, MD 21234
	Regist		NOV 2 2 2004	the parties	

11/18/08 303/m

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Yvonne Marie James November 2135 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Memorial Hospital Easton Talbot 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct. 28, 1 **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 🕱 F Months Days Hours Yrs. 67 215-36-1647 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "naturel", or items 23a or 28a-f shorthe Madical Examiner must be putified at MD Dorchester East New Market Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4378 East New Market-Rhodesdale Road 21631 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I ပ Woodrow Robinson Leona Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21631 Pages 1 and 2 ment of Health a Robert L. James 4378 East New Market-Rhodesdale Rd., E. New Market M husband injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ' 4 □ Donation 5 □ Other (Specify) Salisbury Crematory 11/14/04 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Drian Dinto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** Lung (ance, /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). burial-translt certificate be executed Due to (or as a consequence of); Box 68760 Physiclan/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 2 **X**No Division of Vital 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After Hospitel or Attending 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director; 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

James

10051132

598 Cynwood Dr., Easton, MD

Q61230

Jorge H. Abrego-Garcia M.D.

31. Date filed (Month Ray, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 egistrar's Signature

			1 For State	State of	Maryland / Dep				and M	lental Hy	gien	2004	27070
			Registrar  1. Decedent's Name (First, Middle	, Last)	Ce	ertificat	e or L	Jeath		2. Date of De	Reg. No	£ 0 0 13	37979
	Physic		T 17.1	15en						Month	Da	Year	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution,	12	per)	4b. City,	Town, or	Location o	of Death	100		County of Death	1 0101
			Howard County G	eneral Hos	pital	Colu	ımbia	ì			Н	oward	
п	Funeral		,	6. Sex 7. 1 M 2 □ F	Age (In yrs. last birthday	) If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year,	9. Birth	nplace (State or Foreign intry)
	Director		072-14-2093 Usual Residence of Decedent		83 Yrs.					Mar. 1	4,	1921 New	Jersey
	faryland ehow		10a. State 10b. County		10c. City, Town or I	ocation							10d. Inside City Limits
	e Ma	Director	Maryland Howar	d	Ellicott	City							1 ☐ Yes 2 📉 No
	or 28	Dire	10e. Street and Number			10f. Zip	Code				10g. Ci	tizen of What Cou	intry?
	s 23e	Funeral	4720 Dorsey Hal			210					USA		
"	fter d	Fu	11. Marital Status  1 □ Never Married 2X Marrie	12. Was Deced Armed Forced 1 X Yes 2	es?	If Yes, spec	lent of His lify Cuban	spanic Orig n, Mexican,	jin? (Spe , Puerto l	cify Yes or No Rican, etc.)	>-	<ol> <li>Race - Amer Black, White</li> </ol>	
936	ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date		1 ☐ Yes 2	2 <b>X</b> I No	Specify:				Specify: Wh:	ite
5-0	within 72 hours after death with the Maryland ene. then "neturel", or items 23a or 28a-f ehow te Madical Exis in err. ast be notified at	Completed	15. Decedent' (Specify only highest	s Education grade completed)	(Giv	edent's Usua be kind of wor	k done di	urina most	of workir	10	16b. K	(ind of Business/la	
121	within ane. then	ldm	Elementary/Secondary (0-12)	College (1-4	or 5+) life.	DO NOT us	e retired)	J 9 117001	o, works	<i>'</i> 9			
Maryland 21215-0036	should be filed within and Mental Hygiene. marked other then matic event, Ire M.		17. Father's Name (First, Middle, L	ast)	Mana	ger		18 Mother	r's Namo	(First, Middle,		ility Con	mpany
an	should be nd Mental marked o	To Be	Gustav A. Jenser	n						stina		,	
ary	2 shou and M is mar eumat	-	19a. Informant's Name/Relationsh	p (Type, Print)	19b. Mai	ing Address						or Town, State, Zi	o Code)
	27 Et		Aldona Jensen/w	ife									MD 21042
Baltimore,	m O		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation	3 Bemoval from Sta	20b. Place of Disp	ocition /Nam	on of		love			ocation - City or T	
Ë	Pages Iment of I tant: If it		`4 ☐ Donation 5 ☐ Other (Sp.		W. Arund	el Cre	mato	ry 1	.5, 2	.004	0den	iton, Mai	yland
Baj	permit. Page Department Important: If eny injury or once.		21. Signature of Funerah Service L	censee /	G	2. Name and	Address OMe	of Facility Crema	tion	Servi	ce	P.O. Box	784
	46200		23a. Part1. Enter the disease, or o	Applications that saw	MO1251 Be	ever1v	L.	Heckr	otte	. P.A.	C1a	rksville	MD 21029
	-		shock, or heart failure. List o	nly one cause on eac	h line.	ter the mode	or aying,	, such as c	ardiac oi	respiratory ai	rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	as a consequence of):								day
н	Examiner			Due to (or	as a consequence or):	Tat	la	fect					1 de
	n =	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequence of).	1700	11/	100110	-				1 day
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с									
8760,	cate be executed physician and the burial-transit		rosuming in death) Last	Due to (or	as a consequence of):								
687	death certificate be executed e attending physician and d for use as the burial-transi	Physician/Medical	·	d									
Box (	death certifice attending ph d for use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor								23d. Date of delive	
	death e atte	Icla	in the past 12 months?	4□Pregnan	at time of death 5[	∃Ectopic pre ∃ Other <i>(spe</i>					1	Month	Day Year
P.O.	that the ed by th detache	hys	9 Unknown	9□ Unknowr									
Ś	w requires that the death cer been signed by the attendin should be detached for use	by	Part II. Dther significant condition	<b>^</b>	n but not resulting in the u	inderlying ca	use given	in Part I.		23e. Did to	obacco u	ise contribute to th	ne cause of death?
ord	requires een sign hould be	eted	1 Spirali	on Meun	ONIN					1 U Y	es 21	No 3 □ Prob	ably 4 Unknown
Division of Vital Record	8 8 8	Completed								24a. Was a autop	sy	24b. Were auto	psy findings available apletion of cause of
a	n: Th licate r, pag									perfor 1 ☐ Yes	med? 2 No	death? 1 ☐ Yes	2 DN0
Ħ	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	2 T F D (0 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		Othor			(Check only or			
10	g Phy er this eral d	n: To	27. Manner of Death	1 Inpa	njury 28b. Time o		c. Injury a Work?	+ LI IVUIS		e 5 ☐ Resid 3d. Describe h		Other (Specify occurred	/)
Ö	ttendin death. stor: Aft / the fun	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	Day Year) Injury	м		s 2 No	0				
. <u>≥</u>	l or Atte after de Directo	Certification:	3 Suicide 6 Could no determin	ed 288. Place of	Injury - At home, farm, streetc. (Specify)	eet, factory,	office		28	3f. Location (S City or Town	treet and	d Number or Rura	I Route Number,
	oitel curs af urs af illed ir	Ce									·		
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	difficult. Off the basis	st of my knowledge, deat of examination and/or in	h occurred al vestigation, i	t the time, n my opin	, date and i	place, an	d due to the c	ause(s) date and	and manner as st place, and due to	ated. the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner	Stated.		License n					e signed (Month, i	
,	550		Men	1022	M.A	1	34	612			11	(10 0	12:011
10	XXX		30. Name and address of person wh	no completed cause o	f death (Item 23a) (Type,	Print)		()		5 11	1001	112,0	7004
	Jan.		Steven G	eller Mil	1 9501	1a A	map	olo R	Å	Ellico	17	City Mi	1 2/042
*	Sta		31. Date filed (Month, Day, Year)		strar's Signature	<b>A</b>							
. 0	Registra	ar 🌼 🏖	NOV 1 C	2001	ties . H.	mati)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician Month Year 0130 M Ray James Jones, Jr. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL at EASTON ASTON Memorial Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1X M 2□F 61 **Director** 214-46-4728 Sept 24 1943 Maryland Usual Residence of Decedent the Maryland show 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23e or 28a-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 X No Directo Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25820 Herring Lane 21629 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ☐Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 01 manager Bay Food Produce other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be and Mental is marked Ray James Jones, Sr. Joyce Roach Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If item 27 I Bonnie Johnson/ life partner 25820 Herring Lane Denton, Maryland 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Department Importent: If eny injury or once. 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 11/14/2004 Chester, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PO Box 160 Greensboro, MD 21639 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician Hicohalic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Completed by Physician/Medical the SB esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ŏ in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown been 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 has certificate 1 Yes 2 No of Vital or Attending Physician: in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death . Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred within 24 hours after death. To the Funerel Director: After Division 1 KNatural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital completely filled 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who

32. Registrar's Signature

V 1 7 2004 January & January

inpleted cause of death

ORIGINAL

(Item 23a) (Type, Print)

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cel</i>	artment of rtificate of		nd Mental Hy	giene 001	37981
	Physici		Decedent's Name (First, Middle, Las.     CLEO	LAVAAN	KELLER			2. Date of De Month Novem	eath Day Ye	3. Time of Death 00044:00 p M
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of [		4c. County of [	<b>_</b>
	Funeral Director		Berlin Nursing 5. Social Security Number 6. Se 474-12-9737	7. Age	Ctr. (In yrs. last birthday) 86 Yrs.	Ber1 If Under 1 Yea Months Days	r If Under 24	Min. (Month, Da	rth 9.	ester Birthplace (State or Foreign Country)
			Usuel Residence of Decedent  10a. State  10b. County		10c. City, Town or Lo	cation		9-18	-18	ND 10d. Inside City Limits
	r 28a-f show	Director	Md. Worcest	er	Ocean P	ines			10g. Citizen of Wha	1 XYes 2 No
	death with ms 23a o	Funerai Di	15 Brookside	12. Was Decedent Ev	ver in U.S. 13.	21811	Hispanic Origin	? (Specify Yes or No	USA 14. Race - A	American Indian,
920	a 9	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1		f Yes, specify Cu □ Yes 2⊠No		uerto Rican, etc.)	Specify: W	White, etc.
Maryland 21215-0036	CI G L	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ication le completed) College (1-4or 5+)	(Give	lent's Usual Occu kind of work done DO NOT use retire	e during most of ed)		16b. Kind of Busine	
nd 21	oe filed w tal Hygler d othar th	Be	12 17. Father's Name (First, Middle, Last)		R	ecords		Name (First, Middle		rnment
laryla	s 1 and 2 should be filed within 7 Health and Mental Hyglene. Itam 27 is marked othar than "n other traumatic event, tra Mad	၉	John C. Rindy 19a. Informant's Name/Relationship (7)	γρe, Print)	19b. Mailin	g Address (Stree		E Lintve	dt er, City or Town, Stat	e, Zip Code)
	ges I and Soft Health		Gary Keller  20a. Method of Disposition  1⊠Burial 2 □ Cremation 3 □ F	Son Semoval from State	20b. Place of Dispo-	Birch S sition (Name of patory or other pla		nite Bea:	r Lake.  20c. Location - City	MN 55110 or Town, State
Baltimore,	permit. Pages Department of Important: If i any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licens		Sunset 1	Memoria Name and Addr		11-16	Berlin,	Md.
	90 E 9		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the	se death. Do not ente	llrich er the mode of dy	Funera ing, such as car	al Home diac or respiratory a	Berlin,	Md., 21811  Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c	Consequence of):	arcin	oma			Onset and Death
	Examiner	ner	sa using to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence of):					
,00	cate be executed physician and the burial-transit	Еха	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
68760,	rtificate b ng physic s as the bi	Medicai	IF FEMALE:	d						
.O. Box	that the death certificated by the attending to detached for use as	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1□Live birth 2 { 4□Pregnant at tim 9□Unknown	☐ Fetal death 3 ☐	Ectopic pregnand Other (specify) _	;y		23d. Date of Month	delivery Day Year
Records, P	w requires that the been signed by th should be detache	ted by P	Part II. Other significant conditions cor	ntributing to death but r	not resulting in the un	derlying cause gr	ven in Part I.		_	to the cause of death?  Probably 4 Unknown
	ysician: The law r is certificate has be director, page 2 sh							24a. Was autop perfor 1 \( \text{Yes} \)	an 24b. Were prior death 22 No 1 Y	autopsy findings available to completion of cause of ? es 2 2 No
on of Vital	ding Ph	To B	25. Was case referred to medical examiner?  1	1 Inpatient 28a. Date of Injury (Month, Day Y		28c. Inju	her: ursin		fie) dence 6 ⊟Other (S now injury occurred	pecify)
Division	To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, stre (Specify)		,100 20,10	28f. Location (S City or Tow	Street and Number or In, State)	Rural Route Number,
	To the Hospitai within 24 hours a To tha Funarai I completely filled	edical C	29a. Certifier (Check only one) (Check only one) (Check only one)	sician: To the best of n ner: On the basis of ex and manner stated	tamination and/or invi	occurred at the ti estigation, in my o	me, date and plopinion, death of	ace, and due to the occurred at the time, o	cause(s) and manner date and place, and c	as stated. ue to the cause(s)
)	To th withir To th comp		29b. Signature and title of certifier	led 12	D	29c. Licens	se number	9	29d. Date signed (Mo	onth, Day, Year)
2, t	1.8		32. Name and address of person who co	mplated cause of deat	h (Item 23a) (Type, F	rint)	1200	7 Corns	Je 1	De ligauli
	Sta Registra	.6	31. Date filed (Month, Day, Year)  NGV 1 5 20	400	Signature	ask	Julia	7		4//7

State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MARY KEGLEY NOVEMBER 22 2004 4;35a /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN WASHINGTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 🗓 F Months Days Hours Yrs. Director <u>219-36-3620</u> W. Virginia Usual Residence of Deceden with the Maryland 10a, State 10b. County 10c. City, Town or Location ir than "natural", or Itama 23a or 28a-f show The Wedleal Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Washington Direct Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Itama 23a any injury or other traumatic event, the Wedgel Example 2008. 17419 Amber Drive 21740 Funerai U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Board of Education 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Stephen Hiner Annie Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monna Gayle Clark - Daughter 1191 Palmwood Ct. Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 1 4 □ Donation 5 □ Other (Specify) Hagerstown Crematory 11/22/04 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Altheres clerotic Cardio vascular Discase 57/NS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or rijury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the ald 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe plnous 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen s certificate has b lirector, page 2 st 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No I or Attanding Physician: after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 10X Natural 1 ☐ Yes 2 ☐ No 2 Accident Diractor 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide To the Hospital or within 24 hours aff To the Funaral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) laujeu 028365 11-22-09 \$H 30. Name and address of person who completed causs of death (Item 23a) (Type, Print) SHAFT 368 Will Street Hersestonn 1910 21740 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 22 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Rag. No. Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:14 Delia Virginia Kindsvatter ovember 16 2004 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown It Under 1 Year It Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M 2 🔀 F Yrs. PA **Director** 217-10-2711 85 12/16/1918 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Importent: If Item 271s marked other then "naturel", or Items 27 any injury or other trainmeter. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21742 US 18937 Orchard Terrace Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. ☐Yes 2 XNo 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Daisy Lee Starkey David Haber Brody 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 Pennsylvania Ave. NW, 1112N, Washington DC 20004 Jack H. Kindsvatter / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/19/2004 Berryville, VA ' 4 ☐ Donation 5 ☐ Other (Specify) Green Hill Cemetery 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licenspe 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause the chine. Approximate Interval Between Onset and Peath Immediate Cause (Final EVENE ALNUTA ( **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) Yes 2 No detached 1 9 Unknown 9 Unknown been signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? peq 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 2 🗆 No 1 Yes 1 Tyes Physicien: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No 1 Minpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending 1 Natural 2 Accident 1 🗌 Yes 2 No investigation death the Director: Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only l eu 29c. Libense numbe 29b. Signature 101 8 10 ed cause of eath (Item 23a) (Type, Print) d address of per MET ENER 32. Re State Registrar

			For State Registrar	State of	Marylan		artment of I				giene Reg. No2 () ()	L 37981.
	Physicia /Medic	al	1. Decedent's Name (First, Midda Adriel John Kee	ener					N	Date of Dea Month	Day Yes	
	Examin Funeral	G1	4a. Facility Name (If not institution Washington Cour 5. Social Security Number	ty Hospita	_	last birthday)	4b. City, Town, of Hager  If Under 1 Year  Months Days	stown If Under	24 Hrs. 8	Date of Birt	4c. County of I  Washi  h  Year)  9.	
	Director		216-14-6218 Usual Residence of Decedent  10a. State 10b. Count	1 M 2 □ F		y, Town or Lo		Hours				Maryland  10d. Inside City Limits
	h the Maryl or 28a-f eho	Director	Maryland Wash	nington	M	augans	ville 10f. Zip Code				10g. Citizen of Wha	1 ☐ Yes 2 🖾 No t Country?
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23s or 28s-f show other traumatic event, the Medical Esan franches notified at	by Funerai	14129 Maugansv  11. Marital Status  1  Never Married 2 Ma 3  Widowed 4 Divorce	12. Was Deced Armed Ford 1 ☑ Yes 2	es? 		2176 Was Decedent of If Yes, specify Cub	Hispanic Ori an, Mexical		y Yes or No- an, etc.)	USA  14. Race - Black, V	American Indian, White, etc. Thite
Maryland 21215-0036	i within 72 ho iene. r then "natur ith: Wedital	Completed		nt's Education est grade completed) College (1-4	4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire Cutter	during mos	st of working		16b. Kind of Busin	•
yland ;	ould be filed Mental Hyg larked other latic event,	To Be C	17. Father's Name (First, Middle Clinton John K	eener				Ed	lna Buc	cher K		A. To Code)
re, Mar	is 1 and 2 shoff Health and Item 27 Is mother traum		19a. Informant's Name/Relation  Lorene V. Keen  20a. Method of Disposition	er/Wife	20b. F	14129		ville		laugan	er, City or Town, Sta SVII1e Mo 20c. Location - Cit	21767
Baltimore,	permit. Pages Department of I Importent: If It, any injury or o		1 Surial 2 Cremation 4 Donation 5 Other (	Specify)	late	st Hav	en Cemet	ery		t Have	en Funera	own, Maryland 1 Chapel wn, Md. 21742
	Pnysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	used the deat ch line. Lia St r as a conseq r as a conseq	LENOSL Juence of):	5	ng, such as	cardiac or re	espiratory ar	rest,	Approximate Interval Between Onșet and Death Michell
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	icai	resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	r as a conseq	ancy	⊒Ectopic pregnanc	sy			23d. Date o	f delivery Day Year
P.O.	that the death cer ed by the attendin detached for use	Physician/Med	1 Yes 2 No 9 Unknown  Part II. Other significant condit	9□ Unknov			Other (specify)	ven in Part I	ı.	23e. Did to		te to the cause of death?
Records,	v requires been sign should be	Completed by								24a. Was	an 24b. Wei	Probably 4 Donknown
Vital Re		Be Comp	25. Was case referred to medic examiner?					26. Place	e of Death (C	1 ☐ Yes	rmed? dea 2 No 1	r to completion of cause of th? Yes 2 ☐ No
Division of V	문 = F	10	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pend	28a. Date of		28b. Time o Injury	f 28c. Inju		280		dence 6 Other (now injury occurred	Specify)
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	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical		ing Physicien: To the ball Exeminer: On the ball and manne	sis of examina			opinion, dea		at the time,		due to the cause(s)
			If fort	who completed cause	of death (fee	n 23a) (Type,	( ).	5678	83		boute	17, 7001
5	+-0	te		50	1111	LO Medi	ical Camp	us Rd	., Hag	gersto	wn, MD	21740

	1	- State Unpend Item 2	3a-b,pt.II	,27 per	me G838 12 ertificate of	2=23-04 ta Death	iS Re	g. No.	3/985
		Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death
Physici		John Anthony	Kearnev				Month November	20, 2004	934 a
/Medic Examin		4a. Facility Name (If not institution, give				or Location of Death		4c. County of De	
		1308 Rigbie Hal		In yrs. last birthda	Belca		8. Date of Birth	Harford	I Sirthplace (State or Fore
Funeral Director		5. Social Security Number 6. Sept 489–72–3270	M 2□F	43 Yrs.	Months Days	Hours Min.	Feb. 18	Year) (	Country)
		Usual Residence of Decedent							
ehow	7	10a. State 10b. County	1	Oc. City, Town or					10d. Inside City Limit
28a-f	Director	Maryland Harford  10e. Street and Number		Belca	10f. Zip Code		10	g. Citizen of What	Country?
with March	Ē		Connet			015		USA	,
ms 2;	Jera	1308 Rigbie Hall	12. Was Decedent Ev	er in U.S. 1	3. Was Decedent of h	017 Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Ar	merican Indian,
s 1 and 2 should be filled within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Exertinational Lencillish at	Completed by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give		1 ☐ Yes 2X No	Specify:	nican, etc.,	Black, WI	
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in 72 n na n na	piete	(Specify only highest grade	e completed)	(G	ve kind of work done  DO NOT use retire	during most of work		ob. Itilia of Basillo.	James Ny
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should be fand Mental I s marked of umatic eve	2		learney			_	ane Kidd		=
12 sho		19a. Informant's Name/Relationship (Ty			illing Address (Street				
1 and Health em 27 ther t	1	Mary J. Given / 20a. Method of Disposition	Mother	20b. Place of Dis	7 Paddric			0c. Location - City	
Pages nent of int: If its iry or o		1 Burial 2 Cremation 3 □F	Removal from State		rematory or other pla	· 1	1 01		
artme ortani Injury		4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	өө (	THIOLY C	M. Chr. (	Cellia; 11-2	4-04	street,	aryland
permit. Pages 1 and 2: Department of Health at Important: If Item 27 is any Injury or other trau		POTING ALLEY	as to lot	t-	1317 Cok	esbury Ro	ad, Abina	don, Mar	yland 21009
Derg		23a. Part1. Enter the discase, or complishock, or heart failure. List only or	ications that caused th	death. Do not					Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Cardiac a		a		=		Onset and Death
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death certificate be executed e attending physician and id for use as the burial-transit	0	IF FEMALE:							-
ath ce tendir	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2	Fetal death	3 Ectopic pregnanc	у		23d. Date of d Month	lelivery Day Year
o o	/sici	1  Yes 2 No	4□ Pregnant at tir 9□ Unknown	ne of death	5 ☐ Other (specify) _			1	,
by tac	Ph	Part II. Other significant conditions con	ntributing to death but	not resulting in the	underlying cause gr	ven in Part I.	23e. Did toba	acco use contribute	to the cause of death?
g p g	1 by	Kartageners Syndron		-	, , ,		1 🗆 Yes	s 2 □ No 3 □	Probably 4 Dunknov
uires that the de signed by the a id be detached t							24a. Was an	24b. Were	autopsy findings availab
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law requires been say been say should	ompleted						perform		?
The law requi ate has been a page 2 should	e Complete	25. Was case referred to medical				26. Place of Deat	yes 2	□ No	? es 2□ No
ysician: The law requi s certificate has been a director, page 2 should	Be	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpa	ient 3□ DOA Ott		Yes 2	□ No   1200	? es 2□ No
Physician: The law requirthis certificate has been ral director, page 2 should	To Be	examiner?  (XX) Yes 2 \( \text{No} \)  27. Manner of Death	Hospital: 1   Inpatient 28a. Date of Injury (Month, Day )	28b. Time	of 28c. Inju	ner: 4 ☐ Nursing Ho ry at	Yes 2	□ No □ No □ No □ No □ No □ No □ No □ No	? es 2□ No
ng Physician: The law requifier this certificate has been ineral director, page 2 should	To Be	examiner?  XYes 2 No  27. Manner of Death  1 Yhatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day )	28b. Time (ear) Injur	of 28c. Inju y Wo M 1	ner: 4 ☐ Nursing Ho ry at	yes 2  (Check only one  me 5 \sum Resider  28d. Describe hove	□ No	ns 2□ No necify) at scer
ng Physician: The law requiriter this certificate has been ineral director, page 2 should	To Be	examiner?  (XX) Yes 2 \( \text{No} \)  27. Manner of Death	28a. Date of Injury (Month, Day )	28b. Time Injur	of 28c. Inju Wo	ner: 4 \(\sum \) Nursing Ho ry at rk?	yes 2  (Check only one  me 5 \sum Resider  28d. Describe hove	No Some Souther (Some injury occurred	? es 2□ No
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ng Physician: The law requisiter this certificate has been ineral director, page 2 should	Certification: To Be	examiner?  X Yes 2 No  27. Manner of Death  1 X Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Checkony) 2 X Medical Exami	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. sician: To the best of ner: On the basis of e and manner state	28b. Time Injur  - At home, farm, (Specify)  my knowledge, de xamination and/ord.  th (Item 23a) (Type)	28c. Inju Wo 1 Street, factory, office hath occurred at the triinvestigation, in my office 29c. License, Print)	me, date and place, opinion, death occurse number	Perform Yes 2  In (Check only one me 5  Resider 28d. Describe how 28f. Location (Street, City or Town, and due to the cased at the time, daily 29	nce 6 Sother (Sp. vinjury occurred state)  set and Number or State)  use(s) and manner te and place, and d. Date signed (Moovember 2	Pass 2 No  Recify) at scer  Rural Route Number,  as stated. ue to the cause(s)  nth, Day, Year)

			Sta		partment of Health and I	•	_	
			State Registrar	•	ertificate of Death		10g. No.2004	37986
*	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Dea	Day Year	3. Time of Death
10	/Medic	al	McKlin Allen		4b. City, Town, or Location of Deatl	NOVEMBE	2R 16 200 4 4c. County of Deat	/845 M
	Examir	er	4a. Facility Name (If not institution, give street MEMORIAL HOSPITAL	1	FASTON	1	TALBO	_
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year   If Under 24 Hrs.			nplace (State or Foreign untry)
	Director		226-46-6116 Usual Residence of Decedent	2□ F Yrs.	Months Days Hours Min.	(Month, Day	15, 1940 Vi	
	pue *		Usual Residence of Decedent  10a, State  10b, County	10c. City, Town or	Location			10d. Inside City Limits
	Maryli f sho	ō	Maryland Caroline	Ridpely				1 ☐ Yes 2√2 No
	r 28e-	Director	10e. Street and Number	Tuguy.	10f, Zip Code	T.	10g. Citizen of What Co	untry?
	th witt		11501 Downes Station	Road	21660	ı	United States	of America
	r dea	Funeral	11. Marital Status 12. W	as Decedent Ever in U.S. 13	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen</li> </ol>	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	ncan Indian,
36	s afte	by Fu	If	□Yes 2 [☑No Yes, Give ear or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	
21215-0036	72 hours after death with the Maryland "natural", or Items 23e or 28e-f show idical Examinat must be notified at		15. Decedent's Education	16a. De	cedent's Usual Occupation		16b. Kind of Business/	
215	within 72 ho ene. <b>then "natu</b> ne Medical	plet	(Specify only highest grade com Elementary/Secondary (0-12)	pleted) (Gi life ollege (1-4or 5+)	ve kind of work done during most of wor b. DO NOT use retired)	rking		
21	ix e f	Completed	12		ckDriver		Trucking	
nu	ed fall of o	Be	17. Father's Name (First, Middle, Last)				Maiden Sumame)	
Maryland	N M M	To	Phillip Kelle  19a. Informant's Name/Relationship ( <i>Type</i> , <i>P</i>		Virgin	ia Rice	r City or Town State 7	(in Code)
Ma	교육등교			The second	01 Downes Station		AVEL NOO STRONG	
re,	f Health item 27 other tr		Roseann M. Kelley 20a. Method of Disposition	20b. Place of Dis	eposition (Name of rematory or other place)	Date NI	20c. Location - City or	
Ë	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State	Crematory		Dover, De	elaware
Baltimore,	arth orte		27. Signature of Funeral Service Licenses		22. Name and Address of Facility Moore Funeral H	ome P	Δ	21620
8	Dep Imp		Jacobs E.	. , (0	12 South Second	Street	. Denton	Maryland
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can	ns that caused the death. Do not euse on each line.	enter the mode of dying, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Pnysician	1	Immediate Cause (Final disease or condition resulting in death)	moxic en	cephalopathy			pays
	/Medical Examiner		Todaming in doubly	Due to (or as a consequence of):	hoventilation	Cando	m) 20. 6	Years
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequence of)	noven que man	37.00	7014(	T CALY S
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events  c					
o,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequence of):				
8760,	ate be hysici the bu	licai	d	<u> </u>				
x 68	The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	IF FEMALE:	yes, outcome of pregnancy				
Вох	attend for us	cian	in the past 12 months?	Live birth 2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deli Month	very Day Year
o.	at the de by the a	ysi		Unknown			1.	
٣.	es that gned b		Part II. Other significant conditions contribut		underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
g	w require been sig should b	ed t	End stage rev	al disease		1□Y	es 2□No 3□Pro	obably 4 Unknown
၁၁ခ	law re as be 2 sho	piet	U			24a. Was a	sy prior to d	topsy findings available completion of cause of
- R		Completed by				perfor 1 ☐ Yes	med? death? 2 No 1 ☐ Yes	2)XNo
of Vital Records,	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	al: \ _	Othor	ath (Check only or		
of	Phys this ral dir	To :	1 Yes 2 No	al: 1 ✓ npatient 2 ☐ ER/Outpat a. Date of Injury 28b. Time	ient 3 DOA 4 Nursing P		ence 6 Other (Specow injury occurred	cify)
on	ding I th. : After funer	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injur			,,	
Division	or Attendate death Director: in by the	ifica	a Could not be	e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	treet and Number or Ru	ral Route Number,
Ö	s after s after s all Dir	Certification:	4   Hotticide	building, etc. (Specify)		City of You	n, state)	
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Exeminer: (	o: To the best of my knowledge, de On the basis of examination and/or and manner stated.	eath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the ourred at the time, o	ause(s) and manner as date and place, and due	stated. to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier	. 4	29c. License number	2	29d. Date signed (Month	ı, Day, Year)
			Latshmi Vand	yourathan N	D 005770	L9 1	VOUEMBER	17 2004
			30. Name and address of person who comple	ted cause of death (Item 23a) (Typ	e. Print)			21601
			Lakshmi Vaidyana	than, M.D. 219	South Washingt	on Stre	eet, East	on, MD
••	Sta Regist	ate ( rar	31. Date filed (Month, Day, Year) 1	SZ. negistrar s Signature	and I			
		200	140 4 - 0 5001	Land har help	Per Liferition			

			1 - For State Registrar	State of Maryland / [	Department of Health and M Certificate of Death	lental Hygie <sub>Reg.</sub>	2004	37987
ı	Physici		1. Decedent's Name (First, Middle, La Toseph CAS	HMERE KOSKi		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number)	4b. City, Town, or Location of Death Cambridge MD		4c. County of Dea Porche Stor	
ì	Funeral Director		217-30-9751	Sex 7. Age (In yrs. last bir		8. Date of Birth (Month, Day, Ye	Q Pir	thplace (State or Foreign
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State  10b. County  DORCH	HESTER HURL	n or Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28 unt be not	al Direc	10e. Street and Number 5035 RIVER F	ROAD	10f. Zip Code 21643		Citizen of What Co	ountry?
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or itams 23a or 28a-f show apply follupy or other traumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	erican Indian, de, etc. HITE
0-6171	within 72 ho lene. than "naturi the wedical i	mpleted	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	Education 16a.  College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ng	Kind of Business	Industry  DELIVERY
7 50	tal Hygie d other event, II	Be Co	17. Father's Name (First, Middle, Las	0	111-	(First, Middle, Maid		ND()
aryla	2 should be and Mental is marked of aumatic eve	To	19a. Informant's Name/Relationship	MERE KOSKI (Type, Print) 196	HELEN  Mailing Address (Street and Number or Run		y or Town, State,	HBY Zip Code)
e Z	1 and 2 Health a tem 27 is		KUTH KOSKI WI 20a. Method of Disposition	FE 50 20b. Place o	35 KIVER ROAD, HU 1 Disposition (Name of		10 21 64 Location - City or	Town, State
Бащтог	permit. Pages Department of Important: If it any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ( 14 ☐ Donation 5 ☐ Other (Special	ify) EASTN	ry, crematory or other place) ENDMARKET CEMETERY	17/04 BAS	TNEWM	ARKET, MO
מ	Departiment of the post of the		21. Signiture of Fyneral Service Lice			ET, HEDEK	ALSBURG	6,MD21632
	Physician		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused the death. Do a yone cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence				
	led sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to fer as a consequence				
00/00	ificate be executed g physician and as the burial-transit	ai Examin	that initiated events resulting in death) Last	c	of):			
100)	artificate ling phys e as the	Medical	IF FEMALE:	G				
.O. BOX	the death c y the attend ached for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of del Month	ivery Day Year
ecords, P	equires that en signed b ould be deta	by	Part II. Other significant conditions	contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacc		o the cause of death?
al Reco	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filted in by the funeral director, page 2 should be detached for use as:	Completed				24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of
NII A	nysician is certif director	To Be	25. Was case referred to medical examiner?  1  Yes  No	Hospital: 1 Inpatient 2 ER/Ou	Other	n (Check only one) me 5 Residence	6 □Other (Spe	cify)
о по	oding Ph th. : After th s funeral		27. Manner of wath  Tantal 5 Pending 2 Accident investigated	(Month, Day Year)	Time of njury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred	
UNISION	after dea Director	Certification:	3 Suicide 6 Could not l 4 Homicide determined		arm, street, factory, office	28f. Location (Street City or Town, St		ural Route Number,
	Hospital 24 hours Funeral etely filled	Medical C	29a. Certifier (Check only one)  Check only 2 Medical Exe	hysicien: To the best of my knowledge miner: On the basis of examination an and manner stated.	a, death occurred at the time, date and place, d/or investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of Cartifler	1581112	29c. License number	29d.	Date signed (Mont	h, Day, Year)
			30. Name and addrys of person who	o completed cause of death (Item 23a)	(Type, Print)	11(	14/2004	
		10	31. Date filed (Month, Day, Year)	Byrn St. Cam 32. Registrar's Signature	bridge, MO 216	15		
	Sta Registr		NOV 1 6	2004	Acosto s			

			For State Registrar	State of Mar		artment of F tificate of		Mental Hy	giene Reg. N2 ()	04	37988
	Physici		Decedent's Name (First, Middle, Last     Pearl	Δ	Lavfie	1.1.d		2. Date of De Month Nov •	6, 20	o4 <sup>Year</sup>	3. Time of Death 7:35 PM M
	/Medic Examir		4a. Fecility Name (If not institution, give Salisbury Nursing		· J		r Location of Death		4c. Count	ty of Death	1
	Funeral Director		5. Social Security Number 6. Se	x 7. Age (	In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		rth ay, Year)	9. Birth	place (State or Foreign intry) vland
	D		Usual Residence of Decedent  10a. State  10b. County		Oc. City, Town or Lo	cation					10d. Inside City Limits
	th the Ma or 28a-f s e redities	Director	MD Somerse	t	Princess	Anne 10f. Zip Code			10g. Citizen of	What Cou	1 XYes 2 □ No
	23a	ral	30573 Circle Drive				1853			USA	
36	be filed within 72 hours after death with the Maryland nat Hygiene. So other than "natural", or items 23a or 28a-f show event. The Medical Examinar must be retified at	Completed by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	o- 14. Ha Bla Speci	ack, White	ican Indian, , etc. hite
21215-0036	hin 72 hou e. an "nature Medical E	pieted	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	ucation le completed) College (1-4or 5+)	(Give	lent's Usual Occup kind of work done DO NOT use retired	aurina most of wor	king	16b. Kind of I		
	filled wit Hygiene other the	Con	10	none	Но	memaker				Home	
Maryland	b d la la	To Be	17. Father's Name (First, Middle, Last) Elijah Baker				18. Mother's Nan Birdie N	, ,	e, Maiden Suma	ime)	
lan)	2 sho and is me		19a. Informant's Name/Relationship (T)			g Address (Street	and Number or Ru	ral Route Numb	oer, City or Town	n, State, Zi	p Code)
altimore, N	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic QDCs.		Cheryl Eichelberge 20a. Method of Disposition 128 Burial 2 Cremation 3		20b. Place of Dispo-		arpsburg	MD 217	782 20c. Location	- City or T	own, State
Ĭ	t. Pag rtment rtant: I		* 4 ☐ Donation 5 ☐ Other (Specify,	1	Beechwood	Cemeter			Frinces	s An	ne, ID
Ba	permi Depa Impo any i		21. Signature of Funeral Service Licens	man h			eral Home		noaa Ann	. M	0. 21853
	Physician		23 . Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final	lications that of used th	M00295 111 e death. Do not ente					ie, m	Approximate Interval Between Onset and Death
	/Medical	1	disease or condition resulting in death)	aDue to (or as a c	consequence of):	1004	0	, ,			23
	Examiner		Sequentially list conditions, if any leading to immediate	b. Carpo Due to or as a c	al is	elhed	end /a	ela,		9	rear-
	ted nsit	nine	Cause (Disease or injury	Due to or as a c	consequence on.					-41	. 000-
Ö,	ificate be executed g physician and as the burial-transit	I Examiner	that initiated events resulting in death) Last	Due to (or as a c	consequence of):					1	
68760,	icate by physic s the b	edical		d							
Box (	death cert e attending od for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊡ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2   4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	1			ate of deliv	rery Day Year
Is, P.0	The law requires that the tte has been signed by the bage 2 should be detache	by	Part II. Other significant conditions co	ntributing to death but r	not resulting in the ur	iderlying cause giv	en in Part I.		tobacco use cor	-	the cause of death?
Records,	w require been si should I	leted						24a. Was		Were aut	opsy findings available
		Completed						auto perfe 1 ☐ Yes	ormed? 2 400	prior to co death? 1 ☐ Yes	ompletion of cause of
Vital	sician: Th certificate irector, pag	) Be	25. Was case referred to medical examiner?	Hospital:	2 ER/Outpatien	t 3 DOA Oth	26. Place of Dea		one) idence 6 ⊟Ot	has (Cana	4.)
on of	ding Phys  After this funeral di	tion; To	27. Manner Ceath  1 atural 5 Pending	28a. Date of Injury (Month, Day Y	28b. Time of	28c. Injur Wor			how injury occu		ry)
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certific completely filled in by the funeral director,	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, stre (Specify)	eet, factory, office			(Street and Num wn, State)	ber or Rur	al Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai C		sicien: To the best of r iner: On the basis of ex and manner state	camination and/or inv						
	To the To the Comp	Ň	29b. Signature and title of certifier	hus		29c. Licens	e number	9	29d. Date signe	ed (Month,	Day, Year)
			30. Name and address of person who c	ompleted cause of deal	th (Item 23a) (Type,		00 Civic	Ave So	lichur	EM.	21804
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1	00 GEVEC	AVG + /DQ	у	, 110.	2100-1

State of Maryland / Department of Health and Mental Hygieney For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Marion Edward Longfellow 9:59 A 11 16 2004 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Greensboro 27880 Whiteleysburg Road If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours 1**∑**M 2□F Director 7/27/1930 Maryland 221-20-5909 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County itam 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Harrington DE Kent Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19952 USA 292 Cole-Brit Lane by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If itam 27 le marked other then "natural", or ite 1♥ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 rural carrier U.S. Post Office 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elizabeth Wheeler Longfellow ၉ Paul Leon Longfellow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha Mae Longfellow /spouse 292 Cole-Brit Lane Harrington, DE 19952 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

+□ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State permit. Page Department of Important: If eny injury or once. <sup>5</sup> 4 □ Donation 5 □ Other (Specify) Greensboro Cemetery 11/20/2004 | Greensboro, MD 22. Name and Address of Facility Fleegle and Helfenbein Funeral 21. Signature of Fyneral Service Licensee Home; 106 W. Sunset Ave; Greensboro, MD 21639 Lepla 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebro Vascular accident **Physician** minutes /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending physic IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ -ension 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an erlipidemia autopsy 1 Yes 2 No certificate the Hospital or Attending Physician: Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Natural 5 Pending death. 2 Accident investigation by the after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral Completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 120047534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wafik Zake, MD 920 Market Street Denton, Maryland 21629 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

		ļ	FUI	partment of Health and Menta Pertificate of Death	Hygiene Reg. N2 004 37990
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last)  JOSEPHINE VIRGINIA MURRAY      Facility Name (If not institution, give street and number)  REEDERS MEMORIAL HOME	4b. City, Town, or Location of Death BOONSBORO	vember 16 2004 7:31 pm 4c. County of Death WASHINGTON
	Funeral Director		5. Social Security Number $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	y) If Under 1 Year If Under 24 Hrs. 8. Dat Months Days Hours Min. AUG	e of Birth lace (State or Foreign Country)  9. Birthplace (State or Foreign Country)  WEST VIRGINIA
	ith the Maryland or 28a-f show	Director	10a. State 10b. County 10c. City, Town or I MARYLAND WASHINGTON 10e. Street and Number	CLEAR SPRING  10f. Zip Code	10d. Inside City Limits 1 ☐ Yes 2X No  10g. Citizen of What Country?
5-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mentat Hygiene.  If I tem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at or other traumatic event, the Medical Examinat must be notified at	d by Funeral Directo	1 ☐ Never Married 2 ☑ Married   Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	21722  Was Decedent of Hispanic Origin? (Specify Yelf Yes, specify Cuban, Mexican, Puerto Rican, €  1 ☐ Yes 2 ☑ No Specify:	Black, White, etc.  Specify:  WHITE
d 21215-	s 1 and 2 should be filed within 72 I f Health and Mental Hygiene. Item 27 is marked other than "nat other traumatic event, The Maddisa	Be Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation  e kind of work done during most of working  DELIVERY PERSON  18. Mother's Name (First,	16b. Kind of Business/Industry  NEWSPAPER  Middle, Maiden Surname)
Maryland	id 2 should be th and Menta 27 Is marked 17 aumatic ev	ToB		ANNABEL BUZ ling Address (Street and Number or Rural Route 3 BOYD ROAD, CLEAR SPR	Number, City or Town, State, Zip Code)
3altimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition  1 🔀 Burial 2 Cremation 3 Removal from State  4 Donatton 5 Other (Secify)  20b. Place of Disposition cemetery, or SAMPLES	matory or other place)  MANOR CEM. 11/19/04  22. Name and Address of Facility  ACST FUNERAL HOME	20c. Location - City or Town, State  SHARPSBURG, MARYLAND 6 Old National Pike
	Physician /Medical Examiner	lner	23a. P. 1. Enter the dise or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	B001	atory arrest,  Approximate Interval Between Onset and Death  4 Months
. Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the burlat-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2+☐ No  Due to (or as a consequence of):  d	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
rds, P.O.	w requires that the been signed by th should be detache	by	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 230	e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2☑No 3 ☐ Probably 4 ☐Unknown
al Records,	The taw i ate has bi page 2 sh	Completed		10	a. Was an autopsy performed?  Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
Division of Vital	ng Phys fter this ineral di	Certification: To Be	25. Was case referred to medical examiner?  1	of 28c. Injury at 28d. De Work?  M 1 Yes 2 No	Residence 6 Other (Specify) scribe how injury occurred
Divi	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		28a. Certifier  (Check only  28d. Place of Injury - At home, farm, so building, etc. (Specify)  28d. Place of Injury - At home, farm, so building, etc. (Specify)  28d. Place of Injury - At home, farm, so building, etc. (Specify)	City	ation (Street and Number or Rural Route Number, or Town, State)  Into the cause(s) and manner as stated.  In time date and place, and due to the cause(s)
		Medical	29b. Signature and title of certifier  Address: On the basis of examination and of and manner stated.	29c. License number	29d. Date signed (Month, Day, Year)
5	Sta Registi		On Name and address of person who completed cause of death (Item 23a) (Type Dr. Robert Guedenet 21 Wyand D)  31. Date filed (Month, Day, Year)  NOV 18 2004	er. Keedysville,MD	

DHMH 17 Rev 1/2001

Name Harray Josephine V.

State of Maryland / Department of Health and Mental Hygiene

				Olato ol	ivial ylan		tificate of	Death		Reg. No. 0	04	37991
	Physician	1. Decedent's Name							2. Date of De Month	Dey	Year	3. Time of Death
	/Medical	EDWIN EAR			4 1			4b. City, Town, or L		8, 2004		1:18 PM
	Examiner					N.T.		OAKLAND	ocation of Deet	,	RETT	
		GARRETT C			7. Age (In yrs. k		If Under 1 Yea		8. Date of Bir (Month, Da			ce (State or Foreign
Ľ	Funeral Director	213-01-86 Usuel Residence of D	99	1 M 2 □ F	89	Yrs.	Months Days	Hours Min.	JULY 9	, 1915	Country WV	0
	ylend	10a. Stete	0b. County		10c. City	, Town or Loc	ation				100	d. Inside City Limits
	the Meryler 28e-1 show notified at	MD	GARRET	[	OA	AKLAND						1 X Yes 2 □ No
	or 28	10e. Street end Numb	er				10f. Zip Code			10g. Citizen of	What Country	y?
	23a 23a	615 S. TH	IRD ST				21550			USA		
21215-0036	172 hours after deeth with the Meryland *natural; or items 23s or 28s-1 show added Examinar must be notified at	3 ☐ Widowed 4		Armed For	2X No e	If	/as Decedent of Yes, specify Cu ☐ Yes 2 X No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Specif	ce - Americar ck, White, etc y: WHIT	c.
5-0	72 h natu	(Specify	5. Decedent's I only highest g	Education rede completed)		16e. Decede (Give k	ent's Usual Occur and of work done	ipation e during most of work ed)	cing	16b. Kind of B	usiness/Indu	stry
121		Elementary/Second	lary (0-12)	College (1-	-4or 5+)		O NOT use retir VICE MAN			AUTOM	ARTIF	
2	Hygia Hygia ther ther there	12 17. Father's Neme (F)	irst Middle I as	et)		SERV	TOE TIAN	18. Mother's Nam	e (First Middle			
and	d be fill ked officever	TOUR		CHAEL				ELIZAB			FOYE	
Maryland	2 should be filed within 72 hours and Mantel Hygiena. Is marked other than "natural", surmitic event, the Medical Exp. To Re Commissed by	19a. informant's Nam				19b. Mailing	Address (Stree	at and Number or Rui		er, City or Town,		code)
		MARY MICH	IAEL - V	VIFE		615 8	. THIRD	ST. OAK	LAND, M	D 21550		
ē,	s 1 and 2 should be filed within if Health and Mantel Hygiene. Item 27 is marked other than other traumatic event, the Mantel To Re Common	20a. Method of Dispos				ace of Dispos	ition (Name of atory or other pl	ace)	Date	20c. Location	- City or Town	n, State
Ê	Pages nant of nt: If Its iry or o	1 Burial 2 4 Donation 5		□Removal from S :ify)	state			GARDENS 1	1/22/04	OAKLAN	D. MAF	RYLAND
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: if Item 27 is any Injury or other tra ance.	21. Signature of Fune				22.	Name and Addi	ress of Facility	P.O.	BOX 243	3	
	-	23a Pert1 Enter the	disease or co	Mulications that ca	MOO16			ERAL HOME			-	Approximate
	Physician	23a. Pert1. Enter the shock, or heart	ailure. List onl	y one cause on ea	ach line.						Ir	nterval Between Onset and Death
	/Medical	Immediate Cause (Fi	nal		A CHURT	DENAT	PATITOR				0	DAVC
	Examiner	disease or condition resulting in death)		θ		as a consequ	FAILURE	1			1 0	DAYS
	ة السام				·			NAL BLEED	ING		8	DAYS
	rificate be executed agreement of physician end see the buriel-trensit.	Sequentially list cond if eny, leading to imm cause. Enter Underly Cause (Disease or inj	itions, ediate	b		es a consequ					-	
68760,	s be s	Cause (Disease or inj that initieted events		C	Due to (or	as e consequ	ence of):				-	
h 4	£ 5 2	4	st		,	·	,					
Box	th ce tendi or use	L		d								
0	the attented for u	Part II. Other significa	ent conditions	contributing to dea	ath but not resu	Iting in the un	derlying cause g	iven in Part I.	23b. Did	tobacco use co	ntribute to t	he cause of death?
σ.	The law requires thet the death ce sate has been signed by the attendit page 2 should be detached for use Completed by Physician/	SEVERE AL	ZHEIMEI	R'S DEMEN	NTIA				1 🗆	Yes 2∏ No	3 ☐ Proba	bly 4 ☐ Unknown
ds,	sign d be								24a. Wes	an autopsy	24b. Were	e eutopsy findings
Records,	v require been signatured should be	DIABETES	MELLITU	JS II						rmed?		able prior to pletion of cause seth?
Re	The law ate has be page 2 s								10.	Yes 2 No		Yes 2□ No
	cartificate rector, pag		t to medical					26. Plece of Deat				765 2L NO
of Vital	Physician: This cartificatral director, F. To Be C.:	examiner? 1 ☐ Yes 2 ☑ No		Hospitel:	patient 2 🗆 E	B/Outpetient	3□ DOA O	thar:		dence 6 □Oth	er (Specify)	
	Physical controls of the serial control of the serial con					28b. Time of Injury	28c. Inji			how injury occur		
0	Attending or death.  actor: Afte by the func	1 XNatural 2 ☐ Accident	5 Pending investigation		, Doy ( out)	injury		Yes 2 □ No				
Division	tal or Attending P rs after death. al Director: After t led in by tha funers Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d Zoe. Place	of Injury - At hor	me, farm, stre	et, factory, office		28f. Location (	Street and Numb	ber or Rural F	Route Number,
	tal or its after											
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	29a. Certifier 1 (Check only 2 one)			sis of exeminati			ime, date and place, opinion, death occur				
	within To the To the Comp	29b. Signature end titl	le of certifier	// 1			29c. Licer	ise number		29d. Date signe	d (Month, Da	ıy, Year)
		Kont	to p	rbunk			D272	.05		NOV. 18	3, 200	4
		30. Neme end eddress KARL E. S			of deeth (Item 311 N.			AKLAND, M	D 21550			
	State Registrar	31. Date filed (Mon	0V'Z' 2	2004 32. Ré	egistrer's Signet	ure	could s					

DHMH 16 Rev 6/95

ORIGINAL

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		1 - For State Registrar		-	ertificate of			10 No 2001	37002
Physic	ian	1. Decedent's Name (First, Middle, Last	1)				2. Date of Deat Month	h Day Yea	3. Time of Death C
/Med	ical	Arlena Ardene 4a. Facility Name (If not institution, give			Ah City Town	or Location of Death		4c. County of De	1 3.15 P.M.
Exam	ner	Sacred Near		ital	4b. City, Town, C	hed An	d	0 1 1	SANY
Funera		5. Social Security Number 6. Se		(In yrs. last birtho	Months   Dave		8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
Directo		216 30 1701 Usual Residence of Decedent	□M 2-F	/1 Yrs	5.		June 4,	1933 WV	
yland		10a. State 10b. County		10c. City, Town o					10d. Inside City Limits
e Mar 8a-f s	ctor	WV Mineral		Elk G					1 ☐ Yes 2 X No
and 21215-0036  be filed within 72 hours after death with the Maryland nial Hygiene.  ed other then "neturel; or Items 23a or 28a-f show event. It a Madical Examinar must be netified at	Funeral Director	10e. Street and Number Rtl Box 274			10f. Zip Code 26717	,	11	ng. Citizen of What ( USA	Country?
death ms 23	neral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Si	pecify Yes or No-	14. Race - Ar	nerican Indian,
36 after or Ite	Ful	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 212 No		rican, etc.)	Black, Wi	
hours furel;	Completed by	3X Widowed 4 □ Divorced  15. Decedent's Edu	Year or Dates:	16a. De	ecedent's Usual Occu	nation		Specify: White	
2157 hin 72 90 "08	plet	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5+	(G	live kind of work done fe. DO NOT use retire	during most of world)	king	TOD. THIS OF BUSINESS	a mounty
nd 2121 e filed within al Hygiene. other then vent, the Me	Con	12			Housewife_	40.04.4.4.4	17°	Homemaki	ng
and be fill notal H	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, N		
Baltimore, Maryland 21215-0036 bernit. Pages I and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "neturel; or any naive or other traumatic event, It a Medical Examples in the Medical Examples.	2	Richard Sherwood  19a. Informant's Name/Relationship (7)		19b. M	lailing Address (Street		ine Paug		, Zip Code)
re, Ma		Carroll Mc Robie	2		Rtl Box 2				
Baltimore, permit. Pages 1 ar Depertment of Hea Important: If item any injury or othe		20a. Method of Disposition  1 → Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	20b. Place of Di cemetery,	isposition (Name of crematory or other pla	ice)	Date	20c. Location - City of	or Town, State
Baltim permit. Par Deportment Important:		* 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens		IOOF C	emetery 22. Name and Addre	11/18	/04 E	lk Garden	,wv
Balti permit. Departr Importa any nju		LONG A Y	Sudock		David A.	Burdock ch St. K	FH		
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ox 68760, h certificate be executed ending physician and use as the burial-transit	cal	IF FEMALE: 23b. Was decedent pregnant	c.  Due to (or as a d.	consequence of):  consequence of):  f pregnancy	OF			23d. Date of d	elivery
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	Physici /Medio			nn Miller			-				11	16	0	4_	OH:48HM
	Examir	er	4a. Facility Name (If	111	treet and number	The !		4b. City, Town, or	Location	of Death		4c.	County o	GC.	101
	Funeral		5. Social Security Nu	mber 6. Sex	7.7	Age (In yrs.	last birthday)	If Under 1 Year	If Under	24 Hrs. 8.	Date of Birt (Month, Da	th .	110	9. Birthp	lace (State or Foreign
	Director		234-25-03 Usual Residence of D	317	M 2 XF	3	35 Yrs.	Months Days	Hours		une 1		69 T	cour Vest	Virginia
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Modeul Examiner must be notified at	Completed	(Specif	15. Decedent's Edu fy only highest grad	cation e <i>completed)</i>		(Give	dent's Usual Occupa	durina mos	t of working		16b. Kir	nd of Bus	iness/In	dustry
121	within	mpi	Elementary/Secon	dary (0-12)	College (1-4o	or 5+)		DO NOT use retired dhandler	1)			Boa	ard (	of E	ducation
<b>d</b> 2	filed with Hygiene. othar thai		17. Father's Name (F	First, Middle, Last)			100	ananarer	18. Mothe	er's Name (F	irst, Middle,	Maiden	Sumame	)	
<u>lan</u>	uld be Aental rkad i tic ev	To Be	Paul B	aker					He]	len Wa	rnick				
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene.  If Itam 27 is marked other than 'natural', or Itams 23a or 28a-f show or other traumatic event, the Marical Examiner must be notified at	ľ	19a. Informant's Nar				1	ng Address (Street a							Code)
	1 and 2 Health tam 27 other tra		Gary M 20a. Method of Dispo	iller/Hus	band	20b. P		. Harrisc sition (Name of	on St.	. Pied					wn, State
Jor	Pages nent of h ant: if Ite ary or of		X□ Burial 2□	Cremation 3 P		, c	emetery, crer	natory or other plac Memorial					Keyse	•	
Baltimore,	permit. Page Department of Important: ff any injury or once.		21. Signature of Fun	5 Other (Specify)  neral Service License		/	4.00	. Name and Addres	ss of Facili	tv			_	•	
B	permit. Departr Importa any inju		17.	Way	ni Br	1		Boal Fun 111 Chur	eral ch St	Home . Wes	ternpo	ort.	Md.	215	52
Г			23a. Part1. Enter the shock, or heart	e disease, or compl failure. List only or	ications that caus	ed the deat	h. Do not ent								Approximate Interval Between
	Physician		Immediate Cause (F		Me	fast	wic	ovasi.	an	Co	nau				Onset and Death
	/Medical Examiner		resulting in death)		Due to (or a	as a conseq	uence of):								
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Box	death e atter d for u	iciar	in the past 12 m	nonths?	1 Live birth 4 Pregnant	at time of d		]Ectopic pregnancy ] Other (specify)					Mont		Day Year
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	o de	by	Part II. Other signific	cant conditions cor	ntributing to death	but not res	ulting in the u	nderlying cause give	en in Part I			obacco u: res 2[		oute to th	ably 4 🛣 Unknown
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Vital		e C	25. Was case referre	ed to medical					26 Place	of Death /	1 ☐ Yes Check only o	2 No	11	Yes	2 No
Σ	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2√0 N	No F	lospital: 1 Linpa	atient 2	ER/Outpatier	t 3 DOA Othe	or		5 🗌 Resid		Other	(Specify	<i>(</i> )
n of			27. Manner of Death	5 Pending	28a. Date of Ir (Month, I	njury Day Year)	28b. Time of Injury	Worl			l. Describe h	now injury	occurre	d	
Sio	Attending r death. actor: After by the fune	icati	2 Accident	investigation 6 Could not be	280 Place of	Injume Ai he	ome form str	M 1 ☐ ' eet, factory, office	Yes 2 🗔		Location (9	Stroot on	d Numbor	or Pum	I Route Number,
Division	after din by	Certification:	4 Homicide	determined	building,	etc. (Specif	y)	eet, ractory, onice		201	City or Tow			or nura	r noute reuniber,
	To the Hospital or Attent within 24 hours after death To the Funaral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)	1 <b>⊠</b> Certifying Phy 2☐ Medical Exami	sician: To the be ner: On the basis and manner	of examina	wiedge, deati tion and/or in	n occurred at the time vestigation, in my op	ne, date an pinion, dea	id place, and th occurred	d due to the o at the time, o	cause(s) date and	and mani place, an	ner as st id due to	ated. the cause(s)
	To the vithin 2 To the comple	Me	29b. Signature and t	title of certifier		)		29c. License	e number					(Month,	Day, Year)
			•	1) John	100			Do	04-	18		11	1161	04	•
			30. Name and addre	ess of person who co	ompleted cause o	f death (Item	1 11		ERIA	n/s> 2	Tal.	711	70.0		
	Sta	ate	31. Date filed (Mont)	h. Dex (Year) 1 7	200 32. Regi	strar's Signa	T We.	CUMBE	_1 CLITT	VU /	10k, 0	x/0	02		
	Regist			MAN	6004	Myse.	de de	A CONTRACTOR OF THE PARTY OF TH							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** oloria Q. 11 2220 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Coastel Hospice Salisbury Wiconico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 38 60 1 ☐ M 2 ▼ F Yrs. Director 70 Sept. 27, 1934 Virginia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ? is marked other than "natural, or items 23s or 28s-f show traumatic event, the Medical Examinar maist be notilised at 1 ☐ Yes 2 No Director Dorchester Church Creek MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1971 Church Creek Road 21622 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: White 3. Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Transportation Office Manager 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental h t and 2 should be Health and Ment tam 27 is markac Floyd Condrey Florine Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 731 Joppa Farm Rd. Joppa, Md. 21085 John W. Tyler othar Itam 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ment of H 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 11/15/04 Glen Burnie MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. Brink. But 1700 Locust St., Cambridge, Md. 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dean Immediate Cause (Final disease or condition resulting in death) **Physician** VICTOSTAIL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ig physician and as the burial-transit death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown for Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an certificate has 1 Yes Physician: funeral director, 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ို 1 Yes this Manner of Ceath 28c. Injury at Work? 28d. Describe how injury occurred Certification; Hospital or Attending Natural 5 Pending n 24 hours after death.

The Funaral Diractor: A pletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho To the Funs completely fi Tertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 296. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

NOV 1 6 2004

State of Maryland / Department of Health and Mental Hygien 2 0 0 1

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			1 - State Registrar	Otate of Marylar	Cei	tificate of	Death		leg. No.	3/995
		¥	Decedent's Name (First, Middle, La	ast)				2. Date of Dea	ith	3. Time of Death
	Physicia		Suzanne Arabella	McBride				November	Day Year  1 08 2004	4:16PM
	/Medic Examin		4a. Facility Name (If not institution, gir	ve street and number)		4b. City, Town, o	r Location of Death	1001000	4c. County of Dea	
		•	Doctor's Hospita	1		Lanham			Prince (	George's
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	O Die	hplace (State or Foreign
	Director		482-30-1329	<sup>1□ M</sup> <b>2</b> 75 75	Yrs.	Months Days	Hours Min.	(Month, Day April 3	, 1929 III	inois
	pu ,		Usual Residence of Decedent	10- 6						
	show	<u>.</u>	10a. State 10b. County		ty, Town or Lo	cation				10d. Inside City Limits 1 X Yes 2 □ No
	the Marylan 28e-f show	cto		George's Seal	brook					L.,
	or 2	Dire	10e. Street and Number			10f. Zip Code		1	log. Citizen of What Co	ountry?
	ath w	ral	9549 Elvis Lane			20706			USA	
	er de Items	Funeral Directo	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	l.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "netural", or items 23e or 28e-1 show other transmetic event, the Medical Eventinal raist be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		I□Yes 2∏XNo	Specify:		Specify: TIL	
21215-0036	hour tural	ed t	15. Decedent's E	<u> </u>	16a Deced	ient's Usual Occup	ation		16b. Kind of Business/	nite
15	in 72 "ne" r	Completed	(Specify only highest gr	ade completed)	(Give	kind of work done OO NOT use retired	during most of worki	ing		dddif
212	iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 2	Home	Maker			Own Ho	ome
p	i Hyg other	BeC	17. Father's Name (First, Middle, Las	)			18. Mother's Name	(First, Middle, i		
Maryland	lid be henta ked ic ev	To B	Guy Lewis McNe	il			Claire M	erz		
ary	shound M	-	19a. Informant's Name/Relationship	Type, Print) Husband	19b. Mailin	g Address (Street			r, City or Town, State, 2	Zip Code)
Σ	nd 2 alth a 27 Is		Lt. Col. Donald		9549 E	Elvis Lan	e Seabroo	k, Mary	land 20706	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygene. Importent: If item 27 is marked other than eny injury or other traumetic event, Ira-Maone.		20a. Method of Disposition	20h E	Place of Diego	cition (Nama of			20c. Location - City or	Town, State
E	Page ent c nt: If ry or		1 🔀 Burial 2 □ Cremation 3 □ - 4 □ Donation 5 □ Other (Speci	Removal from State Nat	Arli ional	natory or other place ngton Cemetery	12/1	/04 A	rlington,	Vircinia
alti	mit.		21. Signature of Funeral Service Lice		22	. Name and Addre	ss of Facility Rob	ert E. I	Evans Funer	al Home
ä	permit Depar Impor eny ir once.		1 LA		16	000 Anna	polis Roa	d Bowie	, Maryland	20715
			23a. Part1. Enter the disease, of con shock, or heart failure. List only	pplications that caused the deat			-			Approximate Interval Between
	Pnysician		Immediate Cause (Final	One cause on each line.	-	1. 1	, ,			Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a conseq	uence of):	Strutt	me			
	Examiner			Hans	tone	er				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b.  Due to (or as conseq	uence of):					
	outed id ansit	Examiner	Cause (Disease or injury that initiated events	c						
o,	an an rial-tr		resulting in death) Last	Due to (or as a conseq	uence of):					
68760,	certificate be executed rding physician and use as the burial-transit	Medical		_ d						
_	100 a	led	15.55141.5			-				
Вох	eath cer attendir I for use	_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23d. Date of deli	
	law requires that the death as been signed by the atter 2 should be detached for u	Physiclan/	in the past 12 months? 1 ☐ Yes 2 ☐ NO	4☐Pregnant at time of d		Other (specify)			Month	Day Year
P.0	by the detached	hy	9 ☐ Unknown							
	es tha igned be det	by F	Part II. Other significant conditions	contributing to death but not res	ulting in the ur	iderlying cause give	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ord	w require been si should b							1 🗆 Ye	es 2 No 3 Pro	bably 4 2 Unknown
Records,	aw re as be 2 sh	ple					_	24a. Was a	n 24b. Were au	topsy findings available
m	0 5 0	Completed						perform	ned2 death?	ompletion of cause of
Vital	ien; Th rtificate ctor, pag	Bec	25. Was case referred to medical				26. Place of Death			
f V	Physicien; rthis certific ral director,	0	examiner? 1 🗆 Yes 2 🗖 No	Hospital: 1 ☐ Inpatient 2 ☑	ER/Outpatien	3 □ DOA Oth	er: 4 🗌 Nursing Hor	ne 5 🗆 Reside	nce 6 Other (Spec	rify)
n of	ding Ph n. After th funeral		27. Manner of Death  1 Watural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun World	yat 2 k?	28d. Describe ho	w injury occurred	
Sio	Attending r death. ector: After by the fune	ath	2 Accident investigatio			M 1□	Yes 2 □No			
Division	- 0.5	Certification;	3 ☐ Suicide 6 ☐ Could not be determined			eet, factory, office	2	28f. Location (Sti City or Town	reet and Number or Ru i, State)	ral Route Number,
	ital or its af rel D led it			4			<u> </u>			
	To the Hospital of within 24 hours af To the Funerel D completely filled in	edical	(Check only 2 Medical Exer	nysicien: To the best of my kno miner: On the basis of examina	wledge, death	occurred at the timestigation, in my or	ne, date and place, a pinion, death occurre	and due to the ca	ause(s) and manner as	stated. to the cause(s)
	the the mplet	Med	one)	and manner stated.		20a Linana	a aumbas	1 20	2d Data signed (Adams)	Day Varia
<u> </u>	To Wil	-	29b. Signature and title of certifier	mn		29c. License	16054	5	9d. Date signed (Month	() W
Į.	1		1/1//	7 111,11.		0	0 0 0 / 0		11/01	07
			30. Name and address of person who				- >	4.1	2 2-	
			ALFIE MINGO M. 31. Date filed (Month, Day, Year)	32 Prietrar's Signa	) 5TKEE	I,5017	E 351, 4	AUREC, 1	40 20707	
1:	Sta Registra		NOV 12	2004	At A					

				For State	State of Maryla	nd / De		f Health and i	Mental Hy	giene Reg. 2004	37996
				Registrar  1. Decedent's Name (First, Middle, Las	at)		Ortmouto c	- Boatin	2. Date of Dea		3. Time of Death
		Physici	ian						Month	Day Yea	
		/Medi		ROBERT LEON  4a. Facility Name (If not institution, give			4b Ciby Town	n, or Location of Deatl	Nov. 6	4c. County of De	TOTOUM
U		Examir	ner	4a. Facility (4aille (Il fiot lifstitution, give	Street and number)		4b. City, 1bwi	n, or Eocation of Death	1		
				Salisbury Nursing	and Rehab Ce	nter s last buthe	av) If Under 1 Ye	Salisbur	Y 8. Date of Birt	Wicomic	irthplace (State or Foreign Country)
		Funeral Director			25 M 2□F 91	Yrs	Months   Da		(Month, Da)	Y Year)	
				Usual Residence of Decedent					5/30/	1913 N.S	7
		yland 10W		10a. State 10b. County	10c. C	City, Town o	Location				10d. Inside City Limits
		Mar A	ţō	MD WICOMIC	O NAN	TICO	KF				1 □Yes X□No
		1 28g	Funeral Director	10e. Street and Number	g(111)	*1100	10f. Zip Cod	le		10g. Citizen of What (	Country?
		138 o	0	2713 BANK ROAD			2181	1	_	I.S. A.	
		deat	Jer	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 1		of Hispanic Origin? (S Cuban, Mexican, Puert			nerican Indian,
	9	after or Ita	Ē	1 Never Married 2 Married	1 Yes M No				o rican, etc.)		
	8	ral',	l by	3 XWidowed 4 □ Divorced	Year or Dates:		1 ☐ Yes 2 💢	No Specify:		Specify: BI	ACK
	5-0	72 h	etec	15. Decedent's Ed (Specify only highest grades)	ucation de completed)	16a. De	cedent's Usual Ocive kind of work do	cupation ne during most of wor	kina	16b. Kind of Busines	s/Industry
	21	within 72 hours after death with the Maryland ene. Than "natural", or Itams 23e or 28e-f show te Macical Examiner must be molified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	lif	e. DO NOT use ret	ne during most of wor tired)			
	7	filed with Hygiene ther tha		8		FAR	MER	1	7	GRICULTU	RE
	P I	be fii ital H id ott	Be	17. Father's Name (First, Middle, Last)	_					Maiden Sumame)	
_	<u>y</u>	2 should b and Menti is markad sumatice	2	ROBERT NUTTERS				TERESA			
ROBERT NUTTER	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If team 27 is marked other than "natural; or Itams 23e or 28e-1 show any Injury or other traumatic event, It a Macical Examinet must be notified at once.		19a. Informant's Name/Relationship (7						r, City or Town, State,	Zip Code)
H		l and fealth im 27 har t		THERESA ALLEN/		48:			ILA,PA	19139	T 0
Z	o or	ges tof H		20a. Method of Disposition 1     Burial 2 □ Cremation 3 □	Removal from State	cemetery,	sposition (Name of crematory or other p	olace)	Date	20c. Location - City of	r Iown, State
$\mathbf{RT}$	Ë.	tant:		`4 □Donation 5 □ Other (Specify		BANG	ITT-WHE			ALISBURY	,MD
BE	Baltimore,	permit. Pages 1 and 1 Department of Health Important: If Itam 27 any Injury or othar tr once.		21. Signature of Funeral Service Licen	2	1	ressick	FUNERAL	HOME P	0 вох 61	
RC	_	70 = 9 Q		CAFern WACK	₩ M00416			MD 21814	4		
				23a. Part1. Enter the disclase, or composhock, or heart failure. List only of	mications that caused the dea one cause on each line.	ath. Do not	enter the mode of o	dying, such as cardiac	or respiratory ari	est,	Approximate Interval Between Opset and Death
4	F	hysician		Immediate Cause (Final disease or condition resulting in death)	a Cerefy	V a	Nonc	1			dos
		/Medical Examiner		resulting in doctin)	Due to (or as a conse	equence of):					
			_	Sequentially list conditions	b. Due to (or as a conse	12-					George.
		ed isi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	querice oi).				1	
		and al-trai	хаг	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):					ī
	760,	te be executed ysician and te burial-transit	calE			,					
	687	9 % 9			d						
	×	Jeath certificati attending phy I for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr	nancy				23d. Date of de	livery
	Вох	atter	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		3 □Ectopic pregna: 5 □ Other (specify)			Month	Day Year
	o i	that the de led by the a detached f	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
	۵.	The Taw requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th		Part II. Other significant conditions co	ntributing to death but not re	sulting in the	underlying cause	given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
	sp.	w requires that been signed to should be deta	d by						1 🗆 Y	es 2 □ No 3 □ P	robably 4 Unknown
	Ö	w req beer shou	Completed						24a. Was a	n 24h Were a	utopsy findings available
	Re	ine lav ate has page 2 :	m d						autops perfori	med? prior to death?	completion of cause of
	a	certificate rector, pag	e Co	25. Was case referred to medical				20 51 (5			s 2 No
	of Vital Records,		o Be	avaminer?	Hospital: 1 ☐ Inpatient 2 ☐	TER/Outer	inn 20 00 0	24	th (Check only on		
	o	r this	H- 1	27. Manner at eath	28a. Date of Injury (Month, Day Year)	28b. Time				ence 6 Other (Spe	ecity)
	o	th. Th. After funera	tior	1 ☐ atural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injur	/ W	Vork? □Yes 2□No			
	Division	Attending r death. actor: After by the fune	ertification:	3 ☐ Suicide 6 ☐ Could not be	280. Place of injury - At I	home, farm,	street, factory, offic	>e	28f. Location (St	reet and Number or R	ural Route Number,
	io :	a afte	ert	4 Homicide	building, etc. (Spec.	ury)		- 1	City or Town	7, State)	
		spire nours nera / fille	aC	29a. Certifier 1 Certifying Phy	sician: To the best of my kn	owledge, de	ath occurred at the	time, date and place,	and due to the ca	ause(s) and manner a	s stated.
	-	lo the hospitel of Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Exam	iner: On the basis of examin and manner stated.	ation and/or	investigation, in my	y opinion, death occur	red at the time, d	ate and place, and du	e to the cause(s)
_	4	vithin 2. To the I	Me	29b. Signature and title of certifier			29c. Lice	ense number	2	9d. Date signed (Mon	th, Day, Year)
	) '			Va TATA	Hu		07	2174	-9	14/8/00	-
				30. Name and address of person who c	ompleted cause of death (Ite	m 23a) (Typ	e, Print)	1 2 (	/	1-7-7	
				William H. Rr	Mins Min			200 Civic A	Ave.,Sal	isbury, Md	. 21804
		Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	. /	nks			-
		Registr	ar	NOV 1 2	LUUH DATE	/	a juju				

			1 - For State of Maryland Registrar		artment of l rtificate of		ınd Mental I	lygiene 20	04	37997
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Joshua Lewis Nater				2. Date of Month Nover	Death Ther 11,	2004	3. Time of Death 0246 A M
	Exami		4a. Fecility Name (If not institution, give street and number) Suburban Hospital		4b. City, Town, Bethesd			4c. Co	unty of Death	
	Funeral Director		5. Social Security Number  247-83-7419  6. Sex 1 ★ M 2 □ F  19  19	birthday) Yrs.	If Under 1 Year Months Days		Min. (Month,	Birth Day, Year) 23,198.	Coun	place (State or Foreign of try)  Ch Carolina
	Manyland f show	or	Usuel Residence of Decedent   10a. State   10b. County   10c. City, T							0d. Inside City Limits 1    Yes 2   No
	bath with the Marylands 23a or 28a-f show	I Director	10e. Street and Number	Beth	10f. Zip Code 2088				of What Coun	
21215-0036	thin 72 hours after death with the Maryland e. m. natural; or Items 23a or 28a-f show M. ot cal Examinar must be invitted at	ted by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education	Sa. Dece	Was Decedent of I If Yes, specify Cub 1 ☑ Yes 2 ☐ No	Hispanic Originan, Mexican, Specify:	in? (Specify Yes or Puerto Rican, etc.)	can Spe	Race - America Black, White, e	etc. spanic
21	vithin ne. han *	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	kind of work done DO NOT use retire Defense	during most d)		U.S.	Navy	ustry
Maryland	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If itam 27 is marked other to any injury or other traumatic evant, Its once.	To Be	Joseph A. Nater  19a. Informant's Name/Relationship (Type, Print)	Ob. Admilia		Rox		lkins		
e, Ma	1 and 2 s Health an am 27 ls ithar trau		Roxanne Elkins (Mother)	900	Midway sition (Name of		or Rural Route Nur	s.c.	29621	
altimore,	artment of strant: If it it injury or o		position 2 □ Cremation 3 □ Removal from State ceme	tery, cren wn M	natory or other plac [emorial	1	Date 1/16/04	Anders	on, S.	C
Ba	Department of the control of the con		233. Part1. Enter the disease, or complications that caused the death. D	20	OT CTEAS	Tana A	Home & (	dale. M	ium,P. d. 207	A. 37
	/Medical Examiner than the private that	edical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Final Industrial Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence consequence)  Due to (or as a consequence consequence)	e of):						Approximate Interval Between Onset and Death
P.O. Box 6	in our requires trait une death certification to the second be detached for use as as a spould be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea! 4 □ Pregnant at time of death		Ectopic pregnancy Other (specify)				ate of delivery fonth D	√ Day Year
ords, P	should be deta	by	Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause give	en in Part I.		tobacco use co		cause of death?
		e Completed	25. Was associated the region					opsy formed?	prior to comp death?	sy findings available pletion of cause of
0	urs after death.  aral Diractor: After this illed in by the funeral di	Certification: To B ⊤	27. Manner of Death    Natural   5   Pending investigation   2   2   2   2   2     Sucide   4   Homicide   4   Homicide   2   2   2   2     Pending investigation   6   Could not be determined   2   2   2   2     28a. Date of Injury   28b.	Time of Injury 77 A arm, stre	et, factory, office	er: 4 □ Nursi eat ?? ∕es 2 🌠 No	28f. Location City or To	sidence 6 00 how injury occupy from to voice from to voice from to voice (Street and Numown, State) I	rred Vehille moter aber or Rural F 495 @ U	Poute Number,
oke C	within 24 ho To tha Function	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Physicien: To the best of my knowledge 2 ☐ Medical Exeminer: On the basis of examination a and manner stated.	e, death nd/or inve	occurred at the timestigation, in my op	oinion, death (	place, and due to the poccurred at the time	, date and place	, and due to th	ne cause(s)
	141		30. Name and address of person who completed cause of death (Item 23a)	Office 2	O.C.M			29d. Date sign.		
	Stat		31. Date filed (Month, Day, Year)  32. Begistrar's Signature			eet, B	Baltimore,	Maryla	nd 2120	01
	Registra	•	NOV 15 2004 Drews	4	Boar Mars	g de la companya del companya de la companya del companya de la co				

WayneAPRSONS 216-38-9539
Baltimore. Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

		1 - For State Registrar  1. Decedent's Name (First, Middle, Las			partment of F ertificate of			eg. No.	.004	37999
Physici /Media		Wayne Thomas Pa	7	•			Month	Day	2004	1011
Examir		4a. Facility Name (If not institution, give PUNINSUIA REGIONAL		MAL		r Location of Death		4c. C	County of Death	h 100
Funeral Director		5. Social Security Number 6. Se		e (In yrs. last birthda 2 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12-25-1	Year) 941	9. Birti	hplace (State or Foreig untry) Md.
Mo N		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
8a-fal	Director	Md. Wicomic	20	Delma	ar					1 ☐ Yes 2X No
a or 2	Dire	10e. Street and Number			10f. Zip Code	7.5	1	-	en of What Co	untry?
ms 23	Funeral	8712 Mar-Lynn Dr	12. Was Decedent I	Ever in U.S. 13	218 B. Was Decedent of H If Yes, specify Cuba		ecify Yes or No-		SA 4. Race - Amer	
ntal hygiene. nd other than "natural", or Itams 23a or 28a-f ahow evant, Ita Medical Evac incel be notified at	by	1 ☐ Never Married 2 📆 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 XYes 2 □ N  If Yes, Give  Year or Dates:	1961 <b>–</b> 1964	If Yes, specify Cuba 1 ☐ Yes 2 XNo	an, Mexican, Puerto Specify:	Rican, etc.)	5	Black, White Epecify: Whi	
"natu	letec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Giv	edent's Usual Occup	during most of work	ring	16b. Kind	d of Business/I	Industry
and Mental Hygiene. is marked other than sumatic evant, the Ma	Completed	Elementary/Secondary (0-12)	College (1-4or 5	<b>4</b> )	<i>DO NOT u</i> se <i>retired</i> nal Board	•		Nv.	lon Co.	
al Hyg l other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M			
Ment parked paric e	To	Roger Thomas Pars					Matthews			
Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic elemen.		19a. Informant's Name/Relationship (T			ling Address (Street a					ip Code)
f Healitam 2		Star L. Parsons, 20a. Method of Disposition		20b. Place of Disc	2 Mar-Lynn position (Name of		Delmar,		218/5 ation - City or 1	Fown, State
unt: H		1 X Burial 2 ☐ Cremation 3 ☐ I  4 ☐ Donation 5 ☐ Other (Specify,			omatory or other place	1	2-04	De la	mar. De	
Departm Importa any inju once.		21. Signature of Funeral Service Licens	500		22. Name and Addres	ss of Facility		DCI	mar, De	•
∆ <u>=</u> ≅ 3		- ywith	1.					_		
		23a. Part1. Enter the disease, or comp shock, or hear failure. List only		at a second contract of	IJ E. GIU	ve St. De	lmar, De	3. I	9940 <sub>-</sub>	
			one cause on each lin	the death. Do not en	nter the mode of dying	g, such as cardiac	elmar, Departed or respiratory arre	est,	9940	Approximate Interval Between Onset and Death
•		Immediate Cause (Final disease or condition resulting in death)  a. Conquestive heart failure  Due to (or as a consequence of):								
ysician Medical aminer		Immediate Cause (Final disease or condition resulting in death)	aCong	Θ.	nter the mode of dying	g, such as cardiac (	21mar, De	est,	9940	Interval Between Onset and Death
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ad by the attending physician and detached for use as the burial-transit	Physician/Medical Ex	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or as a d	consequence of):  a consequence of):  a consequence of):  consequence of):  of pregnancy  Consequence of):	meter the mode of dying and fail in the mode of dying and dying and dying and dying and dying and dying and dying and dying and dying and dying and dying and dying and dying and dying a	g, such as cardiac o	or respiratory arre	230	d. Date of deliv	Interval Between Onset and Death
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			1 - State of Maryland / Dep	eartment of Health and Mertificate of Death		ene g. N2004 38000
ı	Physici		Decedent's Name (First, Middle, Last)     LUCY W. PASTORFIELD		2. Date of Death Month	
*	/Medic Examir		4a. Facility Name (If not institution, give street and number)  Penintsula Regional Medical Contact	4b. City, Town, or Location of Death  SALISBURG		4c. County of Death Wicomic o
	Funeral Director		5. Social Security Number  221-03-6273  Usual Residence of Decedent  6. Sex 1  M 27 F  7. Age (In yrs. last birthday 86 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, 09-02-19	9. Birthplace (State or Foreign Country) SNOW HILL, MD.
	Maryland	tor	10a. State         10b. County         10c. City, Town or L           MD         WICOMICO         SALISBUR			10d. Inside City Limits 1 ☐ Yes 2∑ No
	h with the 23a or 28	al Director	10e. Street and Number 426 LOBLOLLY LANE	10f. Zip Code 21801	10	g. Citizen of What Country? USA
0000	be filed within 72 hours after death with the Maryland nat Hygiene. od other then "naturel", or items 23e or 28e-1 show event, the Medical Examinar must be routified at	by Funeral I	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give 14 Yes, Give 15 Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify:  WHITE
7-617	within 72 houne. ne. hen "nature ne Medical E	Completed	(Specify only highest grade completed) (Given Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)	ng	6b. Kind of Business/Industry
and 2	e filed Il Hygia other vent, L	To Be Co	12 2 S 17. Father's Name (First, Middle, Last) ISAAC WILLIAM ADKINS	ECRETARY  18. Mother's Name  LUCY POLL	(First, Middle, M	SCHOOL SYSTEM aiden Surname)
Mary	nd 2 shou ilth and M 27 is mar r treumat	-		ing Address (Street and Number or Rural E. WILLIAM STREET,)	l Route Number,	
animore,	permit. Pages 1 and 2 should b Department of Health and Ments Importent: If item 27 is marked any injury or other treumatic e gnce.		20a Method of Disposition 20b. Place of Disp	osition (Name of Dimatory or other place)	ate 2	Oc. Location - City or Town, State  ALISBURY, MARYLAND
Dall	permit. Departm Importe any inju		21. Ignature of Funeral Service Licensee	2. Name and Address of Facility BOI	UNDS FUN	ERAL HOME, INC. URY, MARYLAND, 21804
	Physician /Medical Examiner		23a. Part 1 Emfer the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	ter the mode of dying, such as cardiac or	r respiratory arres	st, Approximate Interval Between Onset and Death
,0070	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):			
O. DOX OC	that the death certifice led by the attending ph detached for use as t	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
cords, r	w requires that the base of the part of th	ρ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death? 2 □ 40 3 □ Probably 4 □ Unknown
ב ב	rsicien: The law re s certificate has be lirector, page 2 sho	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
SIOII OI VII AI	al o	itlon: To Be	25. Was case referred to medical examiner?   1		******	ce 6 ☐Other (Specify)
	tel or Atter s after dea el Director ed in by the	Certification:	3   Suicide 4   Homicide  6   Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	8f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical (	29a. Certifier (Check only one)  1 Cartifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred	d at the time, date	e and place, and due to the cause(s)
	with To	2	29b. Signature and Attelof continer  Chris Sunder	29c. License number  D.o. H50497	290	I. Date signed (Month, Day, Year)
	ins		30. Name and address of person who completed cause of death (Item 23a) (Type, 100 E. Cauroll St. Sallsburg	Print) WO 21801		\$ VEC
	Sta Registr	- 10	31. Date filed (Month, Day, Year)  NOV 1 2 2004  32. Registrar's Signature	Sporks		